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# BIO-MEDICAL ETHICS

Edited by
Thomas Srampickal

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# Bio-Medical Ethics

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THOMAS SRAMPICKAL

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CONTENTS

# Editorial

The practice of medicine is a field which has been doing yeoman service to the health and well-being of humankind. The great strides medicine and medical technology has made in recent times have considerably enhanced its capacity to allay human sufferings and prevent and cure diseases. At the same time, it can also do immense harm to the life and health of people if it is not practised properly. Such a human enterprise which holds great potential for 'good and bad' cannot but be a moral enterprise. After all, every human endeavour is governed by the general moral principle "do good and avoid evil".

However, medical science as such is not equipped with the principles and norms required to make this discernment regarding good and bad, right and wrong, in the practice of medicine. They belong to the province of Ethics. Hence, the relevance and significance of Medical Ethics. The practitioners have been, from the beginning, aware of the need for ethical guidelines or codes in their application of medicine, the first of which date back to Hippocrates, the Greek physician of the 4th century B.C. Of late, as a result of the immense progress that biological sciences have made, "medical practice" has begun to overstep its traditional frontiers and enter into areas other than cure and prevention of diseases. Experts in medical and associated fields today spend a lot of time, energy and resources in research on life, on the factors and processes that affect the "quality of life", on human reproduction etc. Evidently, all these involve serious ethical issues which are the concerns of ethics of life or what we call today 'Bioethics'. However, Bioethics and Medical Ethics easily tend to form 'Biomedical Ethics' today, which has as its central concern the protection and promotion of human life value and the respect due to it, whether in the practice of medicine or in other scientific and technological research on and experiment with human life.

Biomedical Ethics by its very nature is inter-disciplinary. Therefore, the practitioners of both Biomedicine and Ethics, should acknowledge and respect each other's roles and cooperate with each other. Biomedicine may not ever consider Ethics as an intruder into its field. Medicine has meaning only when it serves the good of the human person – his/her health and well being. After all human person is not merely a collection of cells, tissues, organs, but an embodied spirit, endowed with rationality and freedom and the final destiny of communion with God. Created in the image of God (Gen. 1:26), each person has his/her dignity and value that has to be respected. He/she shall not therefore be looked at, treated or handled as an object for physiological exploration, biochemical experimentation or genetic manipulation. As Edmund Pellegrino, the eminent American professor of medicine and medical ethics, notes, there is a version of Bioethics "which makes biology the justification and judge of all that is right and good. Moral decisions are those that favour survival, purification, or improvement of the gene pool, or simply are congruent with the genetically-determined electro-chemistry of the limbic system. Theological extrapolations of medical ethics built on such a framework are antipathetic indeed to any spiritual view of human nature" (*Linacre Quarterly*, Nov. 1990, p. 26). What is needed is not biologized medicine, but humanized medicine and research. Ethics, on its part, should be in constant touch with the ever growing biomedical field, the strenuous efforts it is making to improve the condition of man and the ground human realities affected by biomedical endeavours. It cannot afford to moralize from an ivory-tower. Ethical vision should also be permeated by integral personalism and not by rigid legalism.

The concerns and problems of Biomedical ethics today are many, all of which cannot be dealt with in a single issue of *Jeevadhara*. We have, therefore, selected a few significant themes which the authors look at from the angle of contemporary debate. Dr. Thomas Kalam, Professor of Moral Theology at Dharmaram Vidyakshetram and Associate Professor of Medical Ethics at St. John's Medical College, Bangalore, writes about "The Making of an Ethical Doctor", explaining the significance of Ethics in medical education and practice, elucidating different ethical

approaches and making very pertinent suggestions for a syllabus for Medical Ethics. Dr. Felix Podimattom, Professor of Moral Theology at St. Francis Theological College, Kottayam, writing about "Early Abortions", cogently argues, on the basis of tradition, probabilism and modern biological research, that the issue is not foreclosed. Dr. Gerald Mathias, Professor of Moral Theology at St. Charles' Seminary, Nagpur, clarifies the concept of "Euthanasia" by explaining the various distinctions of the term, and succinctly gives the norms for the moral assessment of Euthanasia. Finally, this writer discusses the issue of artificial fertilization in the light of contemporary debate. All authors agree on the great ethical significance of Biomedical science and call for the highest sensitivity to moral values, inspired by a personalistic vision of morality.

St. Thomas Apo. Seminary
Vadavathoor
Kottayam - 686 010

Thomas Srampickal

# Euthanasia

## Some modern Euthanasia movements

The debate about euthanasia is not new. Only the emphasis has shifted and the issues have become more complex in the present day. The modern Euthanasia movement took a dramatic turn in Germany in the 1920s and 30s. With the prevalent notion of *Lebensunwerten* ('life not worthy of life' or simply 'worthless' life), it became standard practice for German physicians to terminate lives that were "useless" to society. That policy provided the rationale for the Nazi practice of killing and exterminating the mentally and physically handicapped which ultimately claimed millions of lives in the Holocaust. The horror of that experience and of the war-crimes, in the words of Derek Humphry, "effectively hampered the intellectual and legal progress of the Euthanasia movement" for some four decades or so[1]. But the movement has picked up gradually in recent years.

In the U. S. A. the Euthanasia movement gained importance with the founding of the Euthanasia Society of America in 1938. It had as its agenda the legalization of euthanasia "to allow incurable sufferers to choose immediate death rather than await it in agony"[2]. A 1971 survey of medical students at the University of Washington School of Medicine showed that 90% of the fourth-year medical students and 69% of the first-year students said that they would practise passive euthanasia with a signed statement of the patient. About half the students in both cases favoured change in permitting active euthanasia[3].

In the 1970s and 1980s the movement gained greater importance. The Hemlock Society pressed for active euthanasia

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1 John J. Paris, *Active Euthanasia* in *Theological Studies* 53 (1992), 116.
2 Cf. Ibid.
3. Cf. Ibid., 117.

while EXIT, its English counterpart, did the same in England. In 1979, a Scottish EXIT group published the first guide or 'suicide recipe book' giving detailed descriptions of how to end one's life. Derek Humphry soon followed with his guide on self-deliverance, *Let Me Die Before I Wake*. In 1980 J. Roman proposed in *Exit House*[4] that suicide should be made available to all over eighteen who request it. Derek Humphry in his best selling *Final Exit*[5], which is his latest self-help text advocates suicide for all willing persons. All that is required is a desiring individual and a ready dose of lethal potion[6].

Last year two proposals on medical decisions to end life dominated the euthanasia debate in the U. S. In a November 5, 1991 referendum in Washington State, Proposition 119 (an Amendment to Article 1, Section 2, Chapter 112, Laws of 1979), which would have legalized physician-assisted suicide as well as active euthanasia, was defeated by 54 votes out of 100. The first official ballot title of proposition 119 was: "Shall adult patients who are in a medically terminal condition be permitted to request and receive from the physician aid-in-dying?" "Aid-in-dying" meant "aid in the form of a medical service, provided in person by a physician, that will end the life of a conscious and mentally qualified patient in a dignified, painless, and humane manner, when requested voluntarily by the patient through a written directive... at the time the medical service is to be provided"[7]. This is nothing but physician-assisted suicide and active euthanasia. Had it been approved, the proposition would have authorized physicians directly to kill the dying and suffering patients.

But barely a month later, on December 1, 1991 the federal Patient Self-Determination Act (PSDA) went into effect. That act, passed by Congress, stipulates that every health-care facility receiving Medicare or Medicaid funding, namely hospitals, nursing homes, health-maintenance organizations etc., must inform its patients of their right to decline unwanted medical treatment, including those that potentially prolong life[8].

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4 J. Roman, *Exit House*, New York: Seaview, 1980.

5 D. Humphry, *Final Exit*, Eugene, Oreg: Hemlock Society, 1991.

6 Cf. John J. Paris, *Active Euthanasia*, 117–120.

7 Ibid., 115.

8. Cf. Ibid., 113.

In England the euthanasia movement goes as far back as 1870 when L. A. Tolemache pleaded in the *Fortnightly Review* for legalized euthanasia. In 1935 Dr. Killick Millard founded the *Voluntary Euthanasia Society* which more recently has become the *Society for the Right to Die with Dignity*, or simply EXIT. It is still campaigning actively for legalized euthanasia[9].

In Netherlands active euthanasia is still technically a legal offence. But a provision that an individual is not punishable if caught in a conflict of duties with a need to act has encouraged many to engage in active euthanasia. This is consolidated by the Supreme Court decision in 1984 allowing physicians to practise euthanasia under strict conditions: i) voluntariness or persistent and free request by the patient; ii) a hopeless situation or terminal illness; and iii) consultation with a colleague who confirms the decision making process[10]. This toleration of mercy-killing has already led to some 5000 cases of active euthanasia or assisted suicides a year in the Netherlands.

Carlos F. Gomez[11] reports that most of the cases of euthanasia in the Netherlands go unreported and uninvestigated by public authorities. In his own survey of 26 cases of active euthanasia only 15% had been reported to the prosecutor's office. A survey which was commissioned by the Dutch government under the chairmanship of the Attorney General of the Dutch Supreme Court indicated that "1.8% of deaths in the Netherlands are the result of physician assisted suicide (some put it at 2 to 3%), 54% of the physicians interviewed had participated in at least one case of active euthanasia and another 34%, though they had not done so, were prepared to do so if requested. This survey found that an overwhelming majority of doctors in the Netherlands see euthanasia, under certain circumstances ("loss of dignity, pain, unworthy dying, being dependent on others, tiredness of life"), as an accepted element of medical practice. It also found that there are, in the Netherlands, over 25,000 patients

9 Cf. Augustine Regan, *Suicide, Euthanasia, Abortion* (Unpublished Typescript Companion Volume to *Thou Shalt; Not Kill*), Newcastle: N. S. W. '81 22.

10 Cf. Lisa S. Cahill, *Bioethical Decisions to End Life* in *Theological Studies* 52 (1991), 119.

11 Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands*, NY: Free Press, 1991.

each year who seek assurance from their physicians that they will assist them if life became unbearable. About 9,000 explicit requests are made, each year, of which less than one third are agreed to by physicians[12].

The euthanasia movements are gaining increasing importance as years go by. As medicine and technology make progress, medical intervention succeeds more and more in delaying the moment of death and adds more days, weeks, months and even years to a person's life. Thus a patient, sedated and comatose, tethered by tubes to an array of machinery has become a familiar sight in our high-tech hospitals. Several questions are raised by such situations. What is the best care for a patient in such a condition? What are the moral duties regarding preserving life and preventing suffering and pain? Should life be preserved regardless of the circumstances? Should those seriously impaired, like handicapped new borns or victims of spinal cord injuries be given treatment at all? Can such patients be allowed to die without life-saving medical interventions? Is it ever morally permissible to intervene directly, to hasten death when death is inevitable and the dying process is so anguishing? Should a person suffering a terminal illness be given life-sustaining treatment? Is there a moral difference between not starting a respirator and turning it off once it is on? Is it permissible to relieve pain with drugs which inevitably hasten death? Can a patient morally refuse life-prolonging treatment? These are some of the many questions about the duties and limits of sustaining life and about death and dying that are raised in the ongoing debate on euthanasia[13].

I hope to answer some of these important questions in the course of this article. But before I do that, the term 'euthanasia' itself needs to be explained for it has acquired in our times ambiguous connotations quite different from its etymological meaning and original usage.

## The meaning of Euthanasia

Etymologically the word euthanasia is derived from two Greek words, *eu* (good, well) and *thanatos* (death), thus meaning

12 Cf. John J. Paris, *Active Euthanasia*, 124–125.

13 Cf. Richard M. Gula, *What are they saying about Euthanasia?* New Yerk: Paulist Press, 1986, 1–4.

good death, happy death, comfortable or easy death without severe pain and suffering. Today, however, the word has acquired different connotations. It has acquired "a connotation of violence or evil, making it synonymous with murder and a social policy of killing those suffering from incurable diseases, old age or a serious physical handicap"[14]. It has come to mean some medical intervention whereby the sufferings of sickness or of final agony are reduced even with the risk of suppressing life prematurely. The word euthanasia is also used "in a more particular sense to mean 'mercy killing', for the purpose of putting an end to extreme suffering, or saving abnormal babies, the mentally ill, or the incurably sick from the prolongation, perhaps for many years, of a miserable life, which could impose too heavy a burden on their families or on society"[15]. Thus "by euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all pain and suffering may in this way be eliminated"[16].

However, the term *euthanasia* as well as other terms like *death with dignity*, *mercy killing*, *the right to die* etc., have become more ambiguous today because very often the distinction between killing and letting die disappears into one and the same term which is used to cover not only direct killing but also indirect killing and letting die. Moreover, the word euthanasia is often used with a qualifier: "active" or "passive", "positive" or "negative", "direct" or "indirect", "voluntary" or "non-voluntary", "prenatal", "postnatal", or "adult", and so on. This calls for further clarification and explanation of the various types of euthanasia.

## Different types of euthanasia

### 1. Positive and negative euthanasia

Physicians and authors usually distinguish between positive and negative euthanasia.

*Positive euthanasia* refers to the institution of 'therapies' and actions designed to hasten death. This often goes under the name of 'mercy killing'. A clear example of this would be the act

14 Ibid., 5.

15 Congregation for the Doctrine of the Faith (CDF), *Declaration on Euthanasia*, London: Catholic Truth Society, 1980, 6.

16 Ibid.

of lethal injection of a dose of morphine. The direct intention of positive euthanasia is to put an end to the patient's life. And this is brought about by some positive lethal action. The chief motive advanced by the supporters of positive euthanasia is 'compassion' or 'mercy' (hence 'mercy killing'). But the action undertaken in the name of compassion or mercy is deliberate and direct termination of patient's life, that is, direct intentional killing of a patient either by the physician, nurse, patient's relatives or friends. This is, therefore, euthanasia by commission.

By *negative euthanasia*, on the other hand, is meant the planned omission or withdrawal of treatments that would probably prolong life. The term 'negative euthanasia' is used with different meanings. Sometimes it is used to signify permitting nature to take its course or allowing one to die rather than using immoral means to prolong life. More often it applies to cases in which there is little or no hope of saving the patient's life and so rather than prolonging terminal illness one chooses to end it sooner through withdrawal of therapy[17]. Some people would not hesitate to label as negative euthanasia the decision not to prolong life according to the principles enunciated by Pope Pius XII in 1957 and in the Vatican Declaration on Euthanasia[18]. But negative euthanasia in the strict sense involves a direct intention to shorten life through planned withdrawal or omission of life prolonging treatment. The direct intention here is not to prolong suffering which is considered opposed to the idea of dying with dignity and peace and this is done by means of deliberate omission of even ordinary treatment and care[19].

2. Direct and indirect euthanasia

The difference between direct and indirect euthanasia is based on the factual and moral difference between directness and indirectness at the level of action itself and that of intention.

*Direct euthanasia* means an action or omission which of itself or by intention causes the death of a patient in order to eliminate his suffering[20]. Here something is directly done or omitted with

17 Cf. Bernard Haring, *Medical Ethics*, Middlegreen, Slough; St. Paul Publications, 1982, 145–146.

18 A. A. S. 49 (1957), 1031–1032.

19 Cf. Bernard Haring, *Medical Ethics*, 146–147.

20 Cf. CDF. *Declaration on Euthanasia*, 6.

the direct intention of putting an end to the patient's life so that his suffering and agony may be ended. This is direct intentional killing either by a positive lethal action or by the omission of due care and treatment. The direct object of the action or omission is patient's death.

*Indirect euthanasia*, on the other hand, consists in an action intended for some other purpose, say to relieve pain (e.g. administration of pain-killers), but which has an inevitable side-effect of reducing the patient's life span. Here the deliberate intention is to kill pain (not the patient!) and the administration of pain killers directly does that, but it also has the foreseen and inevitable side-effect of hastening the patient's death. This latter effect is said to be only indirectly intended and tolerated. Though both actions would sooner or later bring the same result, there is a fundamental difference in the intention and the means used and this difference is morally significant.

3. Active and passive euthanasia

By *active euthanasia* is understood the voluntary commission of a life-terminating action. It designates someone's doing something to the patient with the intention of shortening life. It refers, therefore, to any procedure that has as an end the shortening of a patient's life. In other words, it is the direct and deliberate killing of another with the intention of putting an end to the pain and suffering of that other. Active euthanasia is the same as positive and direct euthanasia.

*Passive euthanasia* means allowing oneself or another person who is terminally ill to die when there is no hope that the person will recover. While active euthanasia is killing, passive euthanasia is letting die. Thus, passive euthanasia involves removing or withholding of life-supporting means, such as antibiotics, transfusions, respirators, dialysis and so on, because no reasonable hope of recovery exists for the dying person[21]. Therefore, while in active euthanasia one *causes* something to happen when it can and should be prevented, in passive euthanasia, one *allows* something to happen when there is no way to prevent it[22]. And

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21 Cf. Richard M. Gula, *Op. cit.*, 5.

22 Cf. Benedict Ashley and Kevin D. O'Rourke, *Health Care Ethics. A Theological Analysis*, Missouri: Catholic Hospital Association, 1978, 385.

these two actions are distinct ethically. We should also note here that some authors equate passive euthanasia with negative euthanasia and mean by it a voluntary omission of an ethically obligatory life-preserving action[23].

4. Voluntary and non-voluntary euthanasia

Euthanasia whether active, positive or direct, if done with the consent of the person is called *voluntary euthanasia*. If it is done without the person's consent, it is called *non-voluntary*. Passive, negative and indirect euthanasia can also be voluntary or non-voluntary depending on whether consent is given or not. If the State or society decides to end the life of the handicapped, demented and the so called "worthless" (as during the Nazi regime in Germany), it is called *compulsory* euthanasia.

5. Prenatal, postnatal and adult euthanasia

The victim of euthanasia can be an embryo or fetus, an infant or an adult who is advanced in age, incurably ill, or in a moribund state.

Modern medicine has made great strides in Genetics and genetic screening. Genetic screening techniques today have made it possible to gain a fairly reliable preview of the child *in utero* and to provide diagnostic guidelines in the management of pregnancy and of obstetric procedures and treatments. Techniques like amniocentesis, real-time ultrasonography, fetoscopy, and chorionic villus sampling (CVS), are indeed most beneficial to detect fetal congenital abnormalities, chromosome abnormalities, metabolic disorders, immunodeficient diseases, fetal hemoglobinopathies, hemophilia, neural tube defects, gestational age and multiple gestations, fetal heartbeat and movement etc. These techniques are undoubtedly of great benefit in the management of pregnancy and prenatal treatment. While there are obvious positive benefits, the procedures are also open to abuses. Thus, in most cases of amniocentesis and fetoscopy, if the fetus is found afflicted with untreatable disease or malformation, the pregnancies are terminated[24]. In India amniocentesis is used particularly as a sex determination test, and if the fetus happens to be female it is invariably

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23 Orville N. Griese, *Catholic Identity in Health Care: Principles and Practice* Massachussetts: The Pope John Center, 1987, 343.

24 Cf. Ibid., 105–110.

aborted. These terminations of pregnancies are direct abortions. And this is *prenatal* euthanasia — euthanasia in the womb.

*Postnatal* euthanasia refers to either direct killing of congenitally malformed children or wilful omission of ethically obligatory procedures which are designed to allow them to die. Infant mortality is still pretty high in the world, especially in the under-developed and developing countries. About one third of these deaths are related to genetic factors, such as single-gene disorders, chromosomal disorders, polygenic diseases, teratogenic diseases etc. Granted that victims of many of these diseases will not survive more than a few days or weeks or months, human dignity demands that they be allowed to live out their full span of life with due attention to their basic needs, i. e., nutrition, hydration, ordinary medicine and care. These infants are the most defenceless of God's family. And therefore, any efforts to actively shorten their life or any wilful omission of ordinary care and obligatory procedures with the intention of allowing them to die would be tantamount to euthanasia. This is referred to as postnatal euthanasia. A clearest example of postnatal euthanasia is the celebrated "Baby Doe" case in Bloomington, U. S. A. in 1982 in which the parents of this Down Syndrome infant refused to authorize a simple and routine operation which would have repaired an internal blockage which prevented the infant from ingesting food. The medical personnel of the hospital allowed the infant to starve to death[25].

When the victim of euthanasia is not an embryo, fetus, infant or child, that is, when euthanasia is neither prenatal nor postnatal as described above, the action is normally referred to as *adult* euthanasia. This includes adolescents, adults and elderly persons whether incurably ill, comatose or dying on whom euthanasia is performed.

Having explained the meanings of the term euthanasia and its various qualifiers, we can now move on to deal with some of the significant moral issues that need to be considered in a discussion on euthanasia. Where one stands on these issues has much to do with where one stands on euthanasia.

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25 Cf. Ibid., 111–113.

## The Moral Issues

### Sanctity and inviolability of human life

The Bible presents life as a gift proceeding from God our Creator. It is His most precious gift. Life is the basic good without which no other good is possible.

The value of human life is based on the fact that God created humans in his own image and likeness (Gen. 1:26-27). That value is enhanced by the fact that human life is the object of God's love and care and is under the personal protection of God (Job. 10:12). The human person is so precious in the sight of God that God sent his own Son to die and save him so that he may have life and have it in abundance (Jn 3:16; 1 Jn 4:9).

The sanctity of life (in other words, respect or reverence for life, the dignity of human life, the value of human life) is, in the words of James Gustafson, rightly to be "evoked, grounded and informed" by the religious belief that God is Creator and Sustainer of life and wills its well-being. Similarly Paul Ramsey reminds us that sanctity of life is not a function of the worth any human person attributes to life but that its primary value lies in the relation of life to God: "A man's dignity is an overflow from God's dealing with him, and not primarily an anticipation of anything he will ever be by himself alone"[26]. Thus, this dignity is founded on the fact that the human person is created in the image of God, redeemed by the Son of God and that his ultimate destiny is eternal life with God. This is the bedrock of human dignity and human rights.

Therefore, human life is not merely a physical and biological reality but essentially an ethical and religious reality, characterized by the union of body and soul both destined for eternal life. The health, vigour and vitality of human life ultimately depend upon the integration of the human will with the divine will, the union of the human personality with God[27]. This eternal destiny of man, this ultimate meaning of human life makes it something very precious, sacred and inviolable. That is the theological

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26 As found in Richard M. Gula, *Op. cit.*, 27–28.

27 Cf. George V. Lobo, *Current Problems in Medical Ethics*, Allahabad: St. Paul Publications, 1980, 37–39.

foundation of human dignity which demands respect for every human life from the moment of conception to the time of death.

Therefore, the Church has always firmly upheld the principle of the inviolability of human life. Pope Pius XII was most emphatic when he declared: "Every human being, even a child in the mother's womb, has the right to life directly from God, and not from the parents or from any other human activity. Hence there is no human authority, no science, no medical, eugenic, social, economic or moral 'indication' that can offer or produce a valid juridical title to a direct, deliberate disposal of an innocent life"[28]. The Second Vatican Council also in a strongly worded statement called all attacks against human life as criminal: "All offences against life itself, such as murder, genocide, abortion, euthanasia, and willful suicide...all these and the like are criminal"[29]. Most recently Pope John Paul II writing to all the Bishops of the world lamented over the serious and disturbing phenomenon of the widespread destruction of so many human lives: "There are numerous and violent attacks against human life today, especially against the weakest and most defenceless. Statistical data point to a veritable 'slaughter of the innocents' on a worldwide scale...it seems more urgent than ever that we should forcefully reaffirm our common teaching based on Sacred Scripture and Tradition with regard to the inviolability of innocent human life"[30].

Since all human life is made in the image of God, and all are children of the same Father, all human life is basically equal in value and dignity. There is no such thing as worthless life, whether in the beginning or end of earthly existence. "Even in decrepitude and extreme suffering or abandonment, life is still of great value. Personhood is never lost. For the believer looks forward to continuing personhood in the next world. Hence, once there is human life, till God himself withdraws the breath of life, it may not be directly terminated"[31].

## Dominion and stewardship

Closely related to the principle of sanctity and inviolability

28 Pope Pius XII, *Allocution to Midwives*. A. A. S. 43 (1951), 838.

29 *Gaudium et Spes*, No. 27.

30 *L'Osservatore Romano*, English Weekly Edition, June 24, 1991.

31 George V. Lobo, *Current Problems in Medical Ethics*, 39.

of life is the principle of God's dominion and human stewardship of life. God alone is the Author of life and death. It is Yahweh who kills and makes alive (Dt. 32:39). He alone has the sovereign dominion over human life. He alone is the supreme master over the two key moments in life – birth (conception) and death.

Therefore, no human can ever claim total mastery over one's own or another's life. Humans have no absolute dominion but only stewardship over human life. As Bernard Häring affirms, "Life is entrusted to man's freedom and co-responsibility. He is not an independent lord of his life but a steward under the sovereignty of God"[32]. Since humans have a right only to the use of human life, and not to absolute dominion over it, it follows that killing oneself or another innocent person implies usurpation of a divine prerogative and violation of divine rights. "It is a question of the violation of the divine law, an offence against the dignity of the human person, a crime against life, and an attack on humanity"[33].

## Prolonging life: duty and its limits

It ought to be clear from the above exposition that respect for human life as a basic good demands that no one deliberately destroy innocent human life, either his own or that of another. But respect for human life also imposes on everyone a duty to preserve his or her life. But then what is the extent of this duty? Should life be preserved at all costs, and regardless of the circumstances? Is it necessary in all circumstances to have recourse to all possible remedies? Are there any limits to this duty?

Theologians have always felt that human beings are under an obligation to preserve life. But they have also maintained that this obligation is limited. It is limited, first of all, by the moral law itself, for one would not be permitted to do anything morally evil even if it is necessary to preserve life. Secondly, even when the use of a particular means would be morally unobjectionable, while it may be used, it is not always of obligation[34]. This duty and its limits regarding the preservation of life are to be determined

32 Bernard Haring, *Free and Faithful in Christ*, Vol. 3, Homebush, NSW: St. Paul Publications, 1981, 5.

33 CDF, *Declaration on Euthanasia*, 7.

34 Cf. John Connery, *Prolonging Life: The Duty and its Limits* in *Moral*

according as the means are ordinary or extraordinary, which many contemporary authors prefer to call "proportionate" and "disproportionate" respectively.

## Ordinary/proportionate and extraordinary/disproportionate means

The distinction between ordinary and extraordinary means was first introduced by Banez in 1595 to designate those means of preserving life, which bring negligible pain and those which cause agonizing unbearable pain chiefly in surgical operation which was practically unbearable because of lack of anaesthesia then[35].

Following Francisco de Vitoria (1486-1546) who had insisted that in most cases one is obliged to use only those means which are regularly (*regulariter*) and customarily (*communiter*) employed for the preservation of life, Cardinal de Lugo (1583-1660) putting it in the negative said that one is not obliged to employ extra-ordinary or out-of-the-ordinary means for the preservation of life[36].

Gerald Kelly, a Catholic expert on medico-moral matters and one of the leading moralists of this century, in his now classic interpretation of this distinction, defined the terms as follows:

> *Ordinary* means of preserving life are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience.
>
> *Extraordinary* means of preserving life...(are) all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain or other inconvenience, or which if used, would not offer a reasonable hope of benefit[37].

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*Responsibility in Prolonging Life Decisions*, ed. by D. G. McCarthy and A. S. Moraczewski, St. Louis: The Pope John Center, 1981, 126.

35 Cf. Richard M. Gula, *Op. cit.*, 45.

36 Gary M. Atkinson, *Theological History of Catholic Teaching on Prolonging Life*, in McCarthy — Moraczewski, *Prolonging Life*, 101.

37 Gerald Kelly, *Medico-Moral Problems*, Dublin: Clonmore & Reynolds Ltd., 1960, 129.

The Vatican Declaration on Euthanasia suggests as to how a correct judgment in this regard is to be made: "It will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources"[38].

These terms, then, are not merely descriptive but evaluative. That is to say, they do not merely describe the ease or difficulty in using a particular means of treatment, but they make a judgment regarding the obligations of their use. Thus, ordinary means are morally imperative; extraordinary means are morally permissible, but not obligatory. *Burden* (inconvenience) and *benefit* (usefulness) are the two main things that must be weighed and assessed before making a judgment as to what is ordinary and therefore obligatory, and what is extraordinary and hence optional in preserving or prolonging life[39]. And this is by no means an easy task.

Part of the difficulty arises because of the way the terms ordinary and extraordinary means are understood by doctors and theologians. For doctors, ordinary means are the routine, usual, customary treatments for a given sickness. Extraordinary means in the medical sense would be anything novel or experimental. Thus from a medical point of view, what was extraordinary 50 or 100 years ago (e. g. blood transfusions, intravenous feeding, artificial respirator etc.) may be quite ordinary today. Besides what may be ordinary in Europe or North America today, might still be extraordinary in the poorer countries of Asia and Africa. Ordinary and extraordinary means, then, are relative to the state of medical development at any given time and place.

From a moral or theological point of view, ordinary and extraordinary means are relative to the patient's total condition, not ignoring the state of medical development, of course. This means that non-medical factors must also be considered.

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38 CDF, *Delaration on Euthanasia*, 10.

39 Cf. Richard M. Gula, *Op. cit.*, 46.

Thus for example, a person's value history (beliefs, fears, hopes, life style, personal and social responsibilities), emotional and spiritual capacity, degree of affective interaction, economic situation etc. would have to be taken into account. Other factors that a theologian considers are the burden a particular medical procedure places on the patient (pain, physical and mental hardship, risk, inconvenience etc.) and the benefit (relief of pain, hope of recovery etc.) it brings. There must be a due proportion between the burden involved in a medical procedure and the benefit it brings, the proportion or lack of it being estimated in terms of various factors such as the kind of treatments to be used, the practical possibility of using them, risks involved, the benefits expected, the expenses to be incurred, the condition of the sick person, inconvenience, his bodily and spiritual strength etc.

Therefore, in order to make a proper judgment as to whether a medical procedure is ordinary (proportionate) or extraordinary (disproportionate), we need to know more than the state of medical practice and availability of therapies. For, a procedure which is medically ordinary (standard) can be extraordinary from the moral point of view, because of the burden it places on the patient and/or the minimal benefit it brings. Moreover, what is a simple inconvenience for one might be a grave burden for someone else. What offers a reasonable hope of recovery for one may not offer the same hope for another. Therefore, the ultimate decision as to what is ordinary and therefore obligatory and what is extraordinary and therefore optional must mainly be made by the patient himself/herself or by his/her proxy in the best interests of the patient, when the patient is comatose or incompetent. The doctors can acquaint them with the medical facts in reaching this decision[40].

In this context it could be noted that some authors have introduced what they call "quality of life" as a criterion for deciding what is ordinary and extraordinary or even for justifying not only passive euthanasia but also active euthanasia[41]. Dr. Sporken,

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40 Cf. John Connery, *art. cit.*, 127–128; see also Richard M. Gula, *Op. cit.*, 47–48.

41 Cf. Dr. Sporken, *Le droit de mourir*, Desclee De Brouwer, 1974, 68–69, 155–156 as cited in Augustine Regan, *Suicide, Euthanasia & Abortion*, 31; Richard A McCormick *Notes on Moral Theology* in *Theological*

for instance, seems to distinguish between life and quality of life and considers that when one is no longer able to confront death and its terrors, the mere duration of *quantity of life* is of little account. Richard A. McCormick proposes to have the "kind of life" or quality of life the patient will have as a result of treatment as a determining factor in deciding whether treatment ought to be used. Regarding seriously handicapped newborns he proposes "the potential for human relationships" as a basic criterion. Accordingly, when the potential for human relationship is totally absent (as in anencephalic newborns) or because of the condition of the baby (as in seriously malformed newborns), would be totally subordinated to the mere effort for survival, then life-prolonging measures would be extraordinary and need not be taken[42].

The present author chooses to disagree with these positions of Sporken and McCormick. The distinction between life and the quality of life is artificial and unfounded. What needs to be upheld and reaffirmed in these circumstances is the *equality* of life, that is, the basic equality of the dignity and sanctity of every human life. Human life is to be identified with the living human person. Therefore, "To destroy human life (either by commission or omission) which is really there, however elemental its manifestations, is to destroy and so violate the person. The distinction between the quality of life and life itself, which seems reducible to identifying the person with rational consciousness, can easily open the door to euthanasia for the mentally handicapped, if this condition is permanent"[43]. Seriously handicapped newborns must be given ordinary nursing and medical care especially nutrition and hydration. To put them aside and let them starve to death, is a clear case of a positive omission intended to induce death and is therefore culpable euthanasia.

The Vatican Declaration makes four concrete applications of the limits of duty to preserve life or of the moral permissibility of not using extraordinary (disproportionate) means:

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*Studies* 36 (1975), 117–129; *Theological Studies* 42 (1981), 100–110; *How Brave a New World?* Garden City: Doubleday, 1981, 383–401.

42 Cf. Richard A. McCormick, *How Brave a New World?* 349. See also Richard M. Gula, *Op. cit.*, 59.

43 Augustine Regan, *Op. cit.*, 31.

- If there are no other sufficient remedies, it is permitted, with the patient's consent, to have recourse to the means provided by the most advanced medical techniques, even if these means are still at the experimental stage and are not without a certain risk. But there would be no strict obligation to have recourse to these remedies.
- It is also permitted, with the patient's consent, to interrupt these means, where the results fall short of expectations. That is, when the burdens on the sick person, his family and medical personnel are disproportionate to the benefits or results foreseen.
- One cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not equivalent to suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expenses on the family or community.
- When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted[44].

I think, that is a fairly clear explicitation of the principle of one's duty and its limits regarding the preservation of life.

## Killing and allowing to die

It is sometimes argued that not using extraordinary means and thus allowing a patient to die by letting nature take its course is the same as active killing. It is said that there is no morally significant difference between killing and letting die.

James Rachels, for example, challenges the claim that there is moral difference between killing and letting die. In an attempt to substantiate his contention he compares two cases, one involving direct killing and the other letting die. In the former case, Smith who would gain a large inheritance from the death of his

44 CDF, *Declaration on Euthanasia*, 10–11.

six-year-old cousin, wants the child to die and so he drowns him in the bathtub. In the latter case, Jones who stands to gain from the death of his six-year-old cousin, also wants to see the child dead. The child happens to slip, hit his head, and fall face down in water. He sees it all and allows the child to die. The difference is Smith killed the child but Jones merely let him die. Rachels argues that from the moral point of view both are the same because the intentions are the same and so are the consequences[45].

In the cases described above, Rachels is quite right in claiming that Jones' act of omission or letting the child die is as wrong as Smith's act of killing him. Often there are clear cases in which, on the moral level, there is no difference between killing one and allowing one to die. And that is why the Vatican Declaration on Euthanasia considers as euthanasia not only an action but also an omission which of itself or by intention causes death, in order that all sufferings be eliminated that way[46]. But what Rachels fails to see is that apart from the intention and the consequences, the act and the means used are also morally significant. He also fails to see that not all omissions are wrongful acts of killing. As Augustine Regan explains it, "The physical difference between giving or taking a lethal dose of poison and letting poison already in somebody's system run its course is obvious. Whether or not there is a moral difference depends on whether or not there is an obligation to prevent it... If means to prolong life are deliberately omitted, when their use is indicated and when this is done for the purpose of inducing death, we have a case of direct euthanasia"[47].

From the moral point of view, therefore, it does make a difference whether one causes something to happen when it can and should be prevented, or whether one allows something to happen when there is no obligation to prevent it[48]. As to when

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45 Cf. Richard M. Gula, *Op. cit*, 38. See also James Rachels, *Euthanasia, Killing and Letting Die* in *Ethical Issues Relating to Life and Death*, ed. by John Ladd, New York: Oxford University Press, 1979, 146–163.

46 Cf. CDF, *Declaration on Euthanasia*, 6.

47 Augustine Regan, *Op. cit.*, 36.

48 Cf. B. Ashley – K. D. W'Rourke, *Health Care Ethics*, 385.

such an obligation exists and when it does not, has already been discussed in the previous section on ordinary and extraordinary means of preserving life. And therefore, as long as there is no obligation to use disproportionate means to prolong the dying process and suffering, to allow nature to take its course is not euthanasia. But, in the same circumstances, administering a positive lethal dose to kill the patient even with the intention of alleviating or ending his suffering is active or direct euthanasia. And the difference between the two is indeed morally significant.

## Artificial nutrition and hydration

The question of artificial nutrition and hydration has dominated the contemporary debate over euthanasia for well over a decade now. The issue was made popular by the famous cases in America, such as the Clarence Herbert case in 1981; Baby Doe case in 1982; the Claire Conroy case in 1983; and the most recent U. S. Supreme Court decision in the Nancy Cruzan case in June 1990[49].

There seems to be a fairly widespread consensus among doctors, theologians and jurists that certain life-sustaining treatments like the use of respirator and dialysis, which would be of no real benefit to the patient but only be a great burden to him and his family, can be withheld or withdrawn. But we do not have this same consensus with regard to artificial nutrition and hydration. Providing food and water is considered as basic form of caring for human life. It could be asked with a legitimate concern therefore: "Can something as basic as nutrition and fluids be considered "extraordinary" so that it may be morally permissible to withhold or withdraw them? Is artificial nutrition and hydration a medical procedure or a basic form of human care? Is withdrawing of nutrition and fluids mean necessarily aiming at death? Does the benefit outweigh the burden in the artificial provision of nutrition and hydration? These are some of the key issues that must be resolved before one can decide whether artificial nutrition and hydration can be withheld or withdrawn in the case of a comatose or PVS (persistent vegetative state) patient.

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49 For a brief account of the first three cases, cf. Richard M. Gula, *Op. cit.*, 49–51, and for the Nancy Cruzan case see Lisa S. Cahill, *Bioethical Decisions to End Life*, 108ff.

As regards these key issues Richard McCormick says: "My own opinion on these issues is that the permanently comatose and *some* non-comatose but elderly incompetent patients may be classified broadly as dying; that feeding by I.V. lines and naso-gastric tubes is a medical procedure; that its discontinuance need not involve aiming at the death of such patients; and that the burden-benefit calculus may include, indeed often unavoidably includes, a quality-of-life ingredient, provided we draw the line at the right place"[50].

Indeed we ought to draw the line very carefully and with clear criteria, for when it comes to deciding whether we should withhold or withdraw artificial nutrition and hydration, the potential for abuse of the patient's best interests is all too great.

It is true that providing food and drink is a basic form of human care. But providing artificial nutrition and fluids through intravenous lines, nasogastric and gastrostomy tubes etc., seems more like a medical procedure followed by skilled medical practitioners and carries inherent risks and possible side-effects. The mere fact that it can be considered a medical procedure does not in itself make it extraordinary. But it could sometimes become extraordinary in particular situations because of the excessive costs involved, possible risks and side-effects, burden and discomfort to the dying patient without any benefit accruing to him except a pointless prolongation of life or postponement of death.

Thus, James Childress and Joanne Lynn affirm that adequate nutrition and fluids are a high priority for most patients, but not for all. The presumption is in favour of providing fluids and nutrition. However, when it would bring no benefit to improve the clinical condition of the patient or would be too burdensome so as to cause discomfort to the patient, then nutrition and hydration may be withheld and withdrawn, for it appears to be extraordinary and therefore optional[51]. Of course, the intention here is not directly to cause the death of the patient by omission but to let nature take its course when there is no positive obligation to prevent inevitable death.

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50 As quoted in Richard M. Gula. *Op. cit.*, 56.

51 Cf. Ibid., 52–53.

Gilbert Meilaender, however, disagrees with this position. He says that the permanently unconscious cannot experience the providing of nutrition and hydration as a burden, and so the argument based on burden does not apply. Nor does the argument based on benefit apply since the fluids and nutrition are useful to sustain the life of the non-dying, though comatose, patient. They are, therefore, not useless. He thinks that withholding artificial nutrition and hydration is necessarily killing, killing by starvation and it involves aiming at death. He also considers artificial providing of food and fluids as normal human care and not medical procedure, and therefore it does not come under the category of extraordinary treatment[52].

Meilaender's position appears to be too stringent. Not all cases of withholding or withdrawing nutrition and hydration from the comatose are killing by starvation. Some of these are clearly treatments involving disproportionate burdens even if they are not *medical* in the strictest sense[53]. We cannot speak of all cases of artificial nutrition and hydration in the same vein. Each case must be taken separately. Thus, as the Washington and Oregon bishops state, "Decisions regarding artificially administered nutrition and hydration must be made on a case-by-case basis, in light of the benefits and burdens they entail for the individual patient". And "In appropriate circumstances, the decision to withhold these means of life support can be in accord with Catholic moral reasoning and ought to be respected by medical care givers and the laws of the land"[54].

## The right to die

Many supporters of euthanasia speak of a "right to die" as a moral basis for legalized 'mercy killing'. Therefore, there arises the question whether one has the moral right, on account of some incurable and painful disease from which he is suffering, to ask for death or to consent to his being killed as an act of mercy.

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52 Cf. Ibid., 55.

53 For a good treatment of artificial nutrition and hydration, cf. Russel E. Smith (ed.) *Critical Issues in Contemporary Health Care*, Massachusetts: The Pope John Center, 1989, 45–136; See also Lisa S. Cahill's coverage of this issue in her *Bioethical Decisions to End Life*, 110–119 already cited.

54 As in John J. Paris, *Active Euthanasia*, 123.

The excellent Anglican pamphlet *On Dying Well* brought out by the General Board for Social Responsibility in 1975 points out that the expression 'right to die' suffers from a dangerous ambiguity. It can mean that the individual has the right to determine whether he should live or die, so that he can claim to be assisted in bringing about his death by medical profession; it can mean that he can consent to the doctor ending his life, where pain cannot be controlled; it can mean finally that the patient *in extremis* should not be subjected to troublesome treatments which cannot restore him to health; and doctors may use drugs to control pain even at the risk of shortening life[55].

The term is obviously used by euthanasiasts with dangerous ambiguity. But there are Catholic theologians who speak of the right to die meaning the right to die in a way worthy of human dignity, which does not include any right to active euthanasia. It is important therefore to state the exact sense in which this term is to be used[56].

First, the right to die, properly understood, excludes any right to kill, even with his consent, an incurably ill person, even if he is actually dying, or to use means designed to accelerate his death. Therefore there can be no right, even with their consent, to kill the incurably ill. Nor does a right to kill, or to consent being killed, arise from the fact that one is dying, even with great suffering. As the Vatican Declaration reminds us, the fact that one may be subject to intolerable sufferings, that a patient can be in good faith in asking to be killed and that others may be in good faith in acceding to his request, does not alter that the act requested is, of its nature, death dealing and remains so.

Secondly, the right to die involves the right to use therapeutic means which lessen the pain and anguish of one's dying moments, even with the foreseen, but unintended, result of shortening of life. But one may not administer drugs with the intention of hastening death, which would be a case of direct euthanasia.

Finally, the right to die includes the right not to commence or to discontinue, treatment of an artificial nature, in situations where

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55 Cf. Augustine Regan, *Op. cit.*, 27.

56 The following points are taken from Augustine Regan, *Op. cit.*, 28–38.

it would be a pointless prolongation of life or postponement of death. This point, I think, has been sufficiently clarified in the section on duties and limits of prolonging life in terms of ordinary and extraordinary means.

## Conclusion: Euthanasia and Benemortasia

The prohibition of euthanasia is not arbitrary. It is based on an instinctive appreciation and profound reverence for human life, and on man's eternal destiny. It is based on the perception that life which is created and preserved by God, possesses an inherent right which is totally independent of its social utility. It is founded on the belief that in the sight of God there is no life that is not worth living, for life is valued by God. And it is also based on the truth that to die, as one should, is an acceptance of death or more precisely of dying, as the termination of life, over which man has no more authority than he has over life itself.

Therefore, it follows that man cannot kill himself, cannot directly hasten his death or consent to any such killing or hastening of death because he has a supreme duty of dying well (the original meaning of euthanasia!). But unfortunately, the duty of dying well or the right to a good death is mistakenly identified with dying without pain and suffering so that it is concluded that one may avoid pain by freely killing oneself or consenting to being killed by human intervention[57].

Though it has not won sufficient approval and acceptance, Prof. A. Dyck's suggestion of the word 'benemortasia' whose Latin roots correspond to the Greek roots of euthanasia, is a term that can well represent the Christian approach to death and the ethic of dying well. Dyck says: "An ethic of benemortasia does not stand in opposition to the values of compassion and human freedom. It differs, however, from the ethic of euthanasia in the understanding of how these values are best realized"[58].

The proper Christian approach to death can be spelled out as follows: Death is never to be self-inflicted but accepted from the hand of God. True compassion toward a dying person in

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57 Cf. Ibid., 40–41.

58 A Dyck, *An Alternative to the Ethic of Euthanasia*, in *Ethical Issues in Death and Dying*, ed. by R. F. Weir, New York: Columbia University Press, 1977, 287, as quoted in Augustine Regan ,*Op. cit.*, 41.

his sufferings is to assist him to accept them. A Christian must be assisted to unite his dying moments with those of Christ on the cross. Death and its anguish must be accepted as an acceptance of human finitude, as an act of submission to the will of God, Lord of life and death. True and final liberty is the free acceptance of death and, as far as reasonably possible, of its sufferings and anguish[59].

As the Declaration on Euthanasia so well reminds us, "The pleas of gravely ill people who sometimes ask for death are not to be understood as implying a true desire for euthanasia; in fact it is almost always a case of an anguished plea for help and love. What a sick person needs, besides medical care, is love, the human and supernatural warmth with which the sick person can and ought to be surrounded by all those close to him or her, parents and children, doctors and nurses"[60].

Indeed, if there are patients who ask for death, it is not so much due to physical pain and suffering as due, most often, to psychological anguish of loneliness, rejection and lack of love and care. When a patient feels that the family members do not care for him, that they want him dead, and wait for that moment, that they treat him as a burden, then such a person would hardly have the psychological strength to bear his pain and suffering, and it should come as no surprise if such a person requested death or consented to his being killed. There are millions all over the world who die in utter loneliness and with a painful sense of being unwanted. There are hundreds of thousands in India who die of criminal negligence in hospitals or homes. Fortunately, there are many institutions for the aged and dying which give them compassion and love and bring peace and happiness to their last days. But such care must be found primarily in one's own home provided by children and dear ones. The ethic of benemortasia can find its full realization only in an atmosphere of respect, love, care, concern and compassion of the Christian home.

Gerald J. Mathias

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59 Cf. Augustine Reçan, *Op. cit.*, 41.
60 CDF, *Declaration on Euthanasia*, 7.

# Morality of Early Abortion in Desperate Situations

The main purpose of this article is to determine whether early abortions are morally permissible in desperate conflict situations such as rape and the like. The chief reason why abortion is condemned by Catholic moralists is that it amounts to the killing of an innocent human being. Is the zygote a human being in the sense of possessing a rational soul? When exactly is the rational soul infused into the body? These and similar questions have been debated by scholars for centuries and will, in all probability, never be answered. However, there seems to be a growing opinion among scholars that fetal life does not become individual, personal, human until at least two weeks after the sperm and the egg unite and, as such, destruction of that life in desperate cases would not amount to abortion in the moral sense. This opinion is based on the following arguments.

## I. Support from the Hierarchical Magisterium

The Catechism of the Council of Trent (Roman Catechism), first published in 1566, clearly teaches delayed animation (hominization), while speaking about the mystery of the Incarnation: "But something which goes beyond the order of nature and beyond human intelligence is the fact that, as soon as the Blessed Virgin gave her consent to the Angel's words... at once the most holy body of Christ was formed and a rational soul was joined to it...Nobody can doubt that this was something new and an admirable work of the Holy Spirit, since, in the natural order, no body can be informed by a human soul except after the prescribed space of time"[1].

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1 *Catechismus Romanus ex decreto Concilii Trid. et Pii Quinti jussu primum editus*, Louvain, 1662, p. 36. The same text has been repeated in the

In 1588 Pope Sixtus V published the Bull *Effraenatam*, by which he reserved to the Holy See the excommunication which punished all those who had, in any way whatsoever, brought about "an abortion, or the expulsion of an immature fetus, whether animated or not animated, whether formed or not formed"[2].

Three years later, in 1591, his successor Pope Gregory XIV explained in his Bull *Sedes apostolica* that the severe legislation of his predecessor had not brought about the desired results and threatened eternal salvation of many who were unable or unwilling to send their petitions for absolution to Rome. Hence he deemed it preferable, "where no homicide or no animated fetus is involved, not to punish more strictly than the sacred canons or civil legislation does"[3].

Another witness of the delayed animation theory in the Church is the Roman Ritual. In the 1617 edition, we read: "Nobody enclosed in the mother's womb should be baptized. But should the infant thrust its head and should there be danger of death, let it be baptized on the head... But if it thrusts out some other limb, which shows some vital movement, let it be baptized on this limb, if there is imminent danger"[4]. The Ritual prescribes that baptism be administered in such critical circumstances only if either the head or some limb of the fetus shows, and only if this limb gives a sign of life, only after "quickening". Unorganized fetuses are not to be baptized. A check on successive editions of the Ritual shows that this formula remained unchanged until 1895.

On April 5, 1713, the Holy Office gave the following answer to a submitted question: "In the case under consideration (baptism of an aborted fetus), if there is a reasonable foundation for admitting that the fetus is animated by a rational soul, then it may and must be baptized conditionally. If, however, there is no reasonable foundation, it may by no means be baptized"[5].

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following French editions: Paris, 1702, p. 48: Rouen, 1736, pp. 47–48; Paris, 1826, p. 91; Paris, 1923, p. 50.

2 *Bullarum....amplissima collectio* 5/1, Rome, 1751, 26a.

3 *Ibid.*, p. 275b.

4 *Rituale Romanum Pauli V jussu editum*, Antwerp, 1617, pp. 7–8.

5 *Collectanea de prop. fide* I, Rome, 1907, p. 92.

Another important witness is the twenty-four Theses offered as guidelines for the study of philosophy in Catholic seminaries and universities by the Sacred Congregation of Studies in 1914[6]. The fifteenth thesis states that the human soul, which is created by God, "may be infused into a subject that is sufficiently disposed"[7]. Thesis 13 explains what is meant by this sufficient disposition of the subject: "In living beings...the substantial form, which is known as the soul, requires an organic disposition, that is, heterogeneous parts"[8].

Until 1869, canon law distinguished between unensouled and ensouled fetus in its treatment of the gravity of abortion and the penalties imposed[9]. When the distinction between the ensouled and the unensouled fetus was removed from canon law in 1869, the immediate animation theory gained support and eventually the Church became more closely identified with this theory so that it is now standard practice to assume that the rational soul is present from the moment of fertilization. What is more, it is often assumed that the official Church teaches dogmatically that the rational soul is infused at the moment of conception, an assumption which is reinforced by moral statements of the magisterium. For example, Vatican II states: "Life once conceived, must be protected with the utmost care"[10]. More recently, the *Charter of the Rights of the Family*, published by the Holy See, confirmed that "Human life must be absolutely respected and protected from the moment of conception"[11]. A further confirmation of the sacredness of life from the start came from the *Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation*, issued by the Congregation for the Doctrine of the Faith on February 22, 1987. Here is the statement: "Thus the

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6 *AAS* 6 (1914) pp. 383–386.

7 *Ibid.*, p. 385

8 *Ibid.* For the above sources I have depended heavily on the splendid article of Joseph Donceel entitled, "Immediate Animation and Delayed Hominization", *Theological Studies*, 31 (1970) pp. 89–91.

9 John Noonan, "An almost Absolute Value in History", in: Noonan (ed.), *The Morality of Abortion*, Cambridge, 1970, pp. 38–39.

10 GS., n. 51.

11 Holy See, *Charter of the Rights of the Family*, 4: L' Osservatore Romano, 25 November 1983.

fruit of human generation, from the first moment of its existence, that is to say, from the moment the zygote has formed, demands the unconditional respect that is morally due to the human being in his bodily and spiritual totality. The human being is to be respected and treated as a person from the moment of conception"[12].

It must be noted, however, that these statements are moral judgments rather than metaphysical assertions. The Commission of Vatican II which formulated the statement on prenatal life avoided defining abortion, since it did not consider itself, or the Church, the competent body for deciding the moment after which a full human being is present. It intended to make a moral point "without touching upon the moment of animation"[13].

Similarly, the *Declaration on Procured Abortion* published by the Congregation for the Doctrine of the Faith in 1974, explicitly recognizes philosophical uncertainty about the beginning of an individual human life. Hence it acknowledges the legitimacy of the ontological speculations: "This declaration expressly leaves aside the question of the moment when the spiritual soul is infused. There is not a unanimous tradition on this point and authors are as yet in disagreement"[14]. In this declaration, the Congregation seems to welcome continuing philosophical discussion as to the moment of infusion of the soul, and hence the beginning of human life. But at the same time, it takes a moral position which does not appear to permit debate on the morally appropriate treatment of early embryonic life: "From the moral viewpoint, on the other hand, it is clear that, even if there be some doubt whether the entity conceived is already a human person, it is an objectively serious sin to expose oneself to the danger of committing murder"[15].

Catholic doctrine does not hold for certain that the fetus is a human being right from the moment of conception. It is quite true that many Catholics and theologians defend this position, and that from the middle of the seventeenth to the middle of the

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12 I, 1.

13 *Expensio modorum, Partis secundae*, Resp. 101.

14 *Declaration on Procured Abortion*, note 19. Cf. *Official Catholic Teachings: Love and Sexuality*, Wilmington, 1978, p. 490.

15 *Ibid.*, p. 414.

twentieth century it became the prevailing opinion; but the hierarchical magisterium itself has never taken an official stand on the presence of a rational soul in the zygote from the moment of conception.

In the seventeenth century the magisterium did indeed condemn the opinion that the fetus is not infused with a human soul until birth[16]. One can legitimately conclude from this that the magisterium considers the fetus a human being while still in the womb. But one cannot conclude from it the teaching that the human soul is infused at conception. It is inconceivable that the Church at that time would have condemned the Aristotelian and Thomist opinion that the human soul was not infused until the fetus was formed. One can grant that today, as in the past, the magisterium would look upon later abortions as a species of homicide. But its condemnation of abortion has never been linked to teaching about the time of infusion of the human soul.

In fact, the Church is not competent to decide the moment of animation.

## II. Support from Tradition

From the earliest centuries, a distinction was made between the unformed and the formed fetus, a distinction stemming from the Septuagint translation of Exodus 21:22. Both St. Jerome and St. Augustine, for example, taught that abortion is not homicide until the scattered elements are formed into a body[17].

A parallel line of discussion, that of the process of ensoulment gradually came to be assimilated to the concept of the formed fetus. In early Christian times three theories of the origin of the human soul were discussed. Traducianism claimed that the human soul was generated along with the body at conception. The theory of pre-existence took the Platonic view that the soul had a premundane existence and joined the body at or after conception. Creationism held that the soul was created by God then and there and infused into the developing embryo.

In his canonical collection (1140), Gratian adopted the creationist theory and also asserted that the soul was not infused

16 *Bullarium Romanum* 8, Rome, 1734, p. 81.
17 John Noonan, *loc. cit.*, p. 15.

until the fetus was formed. The creationist theory received additional support from St. Thomas Aquinas, who found it compatible with the Aristotelian view of biology which he integrated into his theological writings. St. Thomas claimed that there was no human being at all during the first few weeks of pregnancy. He felt that at the moment of conception there originated a vegetative organism that would slowly evolve into a sentient organism to become, later on, a rational organism, a real human being. St. Thomas, following Aristotle, considered the soul as the first or substantial act of a physically *organized* body. He insisted that the human embryo must have a certain degree of organization before it could become the seat of a rational principle. It should have at least the beginning of a human shape and the essential organs should be present. St. Thomas never questioned the presence of life in the embryo from the moment of conception. But the first life is vegetative and when the proper organization is attained, a sensitive principle replaces the vegetative. When there is adequate organization appropriate for the presence of the rational soul, God creates it and infuses it into the body.

Thomistic metaphysics accepts the theory of hylomorphism according to which matter and form are the constitutive causes of being. There is a reciprocal causality between matter and form so that the form can be received only into a matter that is capable of receiving it. A piece of paper, for instance, cannot receive the form of a human soul or even the form of a violin because the matter is not disposed to receive it. So, it is argued, the zygote in the very beginning is not capable of receiving a human form – the rational soul.

St. Alphonsus Liguori mentions the prevailing opinion of his time, namely, that the fetus has a soul from the moment of its conception, or at least after a few days. But he warns that "not every lump of flesh should be baptized which lacks the adequate arrangement of organs, since it is universally accepted that the soul is not infused into the body before the latter is formed; in which case it can only be baptized if it *shows some kind of vital movement*, as prescribed by the Roman Ritual"[18]. And elsewhere he writes: "On the other hand, some are mistaken

18 *Theologia moralis* 6, Bassani, 1779, p. 107.

who say that the fetus is ensouled from the first moment of its conception, since the fetus is certainly not animated before it is formed"[19].

In the centuries following St. Alphonsus Liguori, several theologians held or favoured the theory of delayed animation. H. M. Hering lists the following names among them. He names Liberatore, Zigliara, Cornoldi, Lorenzelli, Sanseverino and di Maria from the end of the last century. From the more recent authors he mentions Cardinal Mercier, Remer, Sertillanges, Prümmer, Barbedette, Vermeersch, Merkelbach, Pirotta, Carbone, Maquart, Jolivet, Lanza Messenger, Lacroix and Barbado[20].

Among the contemporary authors, Richard McCormick describes the embryo during the first two weeks as "nascent human life" but does not consider it an "individual human life" until later[21]. Charles Curran concurs with McCormick, stating that "truly individual human life should be judged to be present two to three weeks after conception"[22]. Karl Rahner asserts that during the first few weeks the existence of a human subject is seriously doubtful[23].

Joseph Donceel feels certain that there is no human person until several weeks have elapsed after fertilization. Philosophically speaking, we can be certain that an organism is a human person only from its activities. The most typically human activity is reflection, self-awareness, the power of saying "I". Of course, if we have to wait until a child says "I", we would have to delay hominization until long after birth. The Church has condemned this position (DS 2135) and rightly so. When we sleep or have fainted, we possess no self-awareness either, yet we remain human beings; we remain capable of such activities. A person in the ultimate stages of senility may give no more sign of self-awareness, yet he still possesses the organs required for such

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19 *Ibid.*, 3, p. 159.

20 H. M. Hering, "De tempore animationis foetus humani", *Angelicum*, 28 (1951) pp. 18–29.

21 Richard McCormick, "Notes on Moral Theology: 1978", *Theological Studies*, 40 (1979) pp. 108–109.

22 Charles Curran, *Moral Theology: A Continuing Journey*, Notre Dame, 1982, p. 125.

23 Karl Rahner, *Theological Investigations* 9, New York, 1972, p. 236.

activity. Donceel concludes that the least we may ask before admitting the presence of a human soul is the availability of the senses, the nervous system, the brain, and especially the cortex[24].

## III. Support from Modern Biological Research

There are reasons in reproductive biology for saying that the fertilized ovum is not a human being yet. Modern embryology has made us aware of certain phenomena which point to the absence of a *personal* life centre in the fertilized ovum although there is a biological centre without which cells could not live and develop.

One such phenomenon is that of identical twins where the developing ovum splits after fertilization into two independent ova which become two distinct persons, thereby casting doubt on the contention that every fertilized ovum is the beginning of an essential continuity of life from fertilization to death. As against the theory of immediate animation, this phenomenon throws up the problem of explaining how this one fertilized ovum can split into two or more parts which then develop of themselves. The spirituality of the rational soul rules out divisibility. A human person does not split into two or more human persons.

To complicate the situation further, it is now possible, according to some experts, for the twins to be re-fused or recombined into one individual being, which makes the claim of "irreversible individuality" of the fertilized ovum highly suspect[25]. The contention that the fertilized ovum has sufficient individuation for its being personal is thus difficult to maintain. If the fecundated ovum can split into two beings which turn out to be two persons, it is difficult to admit that at first it was itself a person, hence fully human.

Twinning may occur within fourteen days after fertilization. This indicates that individual human life is not definitely established before this time. Corroborating evidence is the fact that a great number of fecundated ova are expelled from the womb

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24 Joseph Donceel, *loc. cit.*, p. 101.

25 *Pre-Implantation Stages of Pregnancy Cibu Foundation Symposium*, 1965, pp. 194–216.

before they could ever reach this stage of the fourteenth day. Research scientists hold that approximately one third of all conceptions result in natural abortion.

In this connection, Karl Rahner makes the following remarks: "For a few centuries Catholic moral theology has been convinced that individual hominization occurs at the moment of the fusion of gametes. Will the moral theologian still have today the courage to maintain this presupposition of many of his moral theological statements, when he is suddenly told that, from the start, 50 per cent of the fecundated female ova never reach nidification in the uterus? Will he be able to admit that 50 per cent of the 'human beings' – real human beings with an 'immortal' soul and an eternal destiny – do not, from the very start, get beyond this first stage of a human existence?"[26].

H. de Dorlodot puts it more bluntly: "In the same way, we should have to insist that a search should be made in the menstrual flow of every woman who has had sufficiently recent matrimonial intercourse to see if there were not some germs there, or better still, we ought to pour baptismal water on this blood, taking care that the water should penetrate everywhere, and pronounce *sub conditione* the baptismal words. For it is quite possible, on the immediate animation theory, that this menstrual blood contains a fecundated ovum in process of development"[27].

From our preceding discussion, it should be clear that there is at least a serious doubt about immediate animation or hominization. As such, we are deemed justified in having recourse to the theory of delayed hominization in desperate situations of rape and the like, and giving the benefit of doubt to the outraged women.

## IV. Difficulties Answered

Traditional moralists insist that here we are concerned with a *doubt of fact* rather than a *doubt of law*. In the case of doubt of law, probabilism may be used, but never in the case of doubt of fact, if the doubt involves life, justice, or the validity of

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26 Karl Rahner, *Schriften zur Theologie* 8, Einsiedeln, 1967, p. 287.

27 H. de Dorlodot, "A Vindication of the Mediate Animation Theory", in: E. C. Messenger (ed.), *Theology and Evolution*, London, 1949, p. 279.

contracts. In such cases, the safer course is to be followed, which in the present case, is the theory of immediate animation.

Carol Tauer, in an enlightening article, denies that in the case of a zygote we are dealing with a doubt of fact and argues his point rather convincingly[28]. Here is a summary of his views.

What is the meaning of the factual. In contemporary philosophy the word "fact" is customarily defined either as a state of affairs in the world or as a true proposition about the state of affairs. The states of affairs in question obtain within our spatio-temporal world and the truth of a factual proposition is verifiable, in principle at least, by empirical methods. Frederick Suppe, a noted philosopher of science, thus presents a standard definition of "fact" when he says: "Facts are what empirically true propositions state or assert about the world"[29].

Suppe's definition restricts facts to states of affairs which are empirically observable within the spatio-temporal world. In this conceptualization facts are the result of the ordinary observation of physical entities and events in everyday life, or else the product of scientific observation and study of these phenomena. Attempts to extend the notion of "fact" beyond this domain appear to lead to conceptual confusions. For example, when Raphael Demos, a philosopher of religion, holds that religion as well as science has its facts, he has to recognize that it has a different definition of "fact"[30]. Just what this definition is, is not clear; but certainly it does not include empirical verifiability. John Hick, another philosopher of religion, attempts to include some religious or philosophical beliefs in the category of the factual by claiming that they are empirically verifiable. In his essay on the immortality of the human soul he claims that this issue is a factual one because it will be verifiable after death[31].

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28 "The Tradition of Probabilism and the Moral Status of the Early Embryo", *Theological Studies*, 45 (1984) pp. 3–33.

29 Frederick Suppe, "Facts and Empirical Truth", *Canadian Journal of Philosophy*, 3 (1973) p. 201.

30 Raphael Demos, "Are Religious Dogmas Cognitive and Meaningful?" in Ronald Sontoni (ed.), *Religious Language and the Problem of Religious Knowledge*, Bloomington, 1968, p. 271.

31 John Hick, "Theology and Verification", in Santoni (ed.), *Religious Language*, pp. 367–371

In his article, "Is the Fetus a Person?" Albert Di Ianni calls the status of the fetus a "human fact", a type of fact which supposedly can be inferred from a combination of empirical and value judgments[32]. This sort of fact does not describe a state of affairs at all, but rather is a proposition which is taken to be true because it follows from empirical facts when seen in the light of particular value commitments or assumptions. Di Ianni holds that a statement such as "The fetus at eight weeks is a person" belongs to the category of human facts, because its truth depends not only on empirical data but also on the relative weight given to the values involved. If one attaches a greater value to human life itself than to privacy and autonomy, then one will choose to recognize the statement as true; if one's value priorities are the reverse, then one will not. The *truth* of the given statement thus depends at least partly on the values one wishes to support.

In order to avoid conceptual muddles which arise from dividing propositions into two classes of factual and evaluative, a third category, that of "theory", is helpful. A theory is a body of concepts and propositions which attempts to provide an adequate explanation for what is empirically observed. While a theoretical proposition is descriptive, it goes beyond the empirical as it fulfils its explanatory function. Many of the propositions of natural sciences are theoretical in nature; they are devised and tested as causal explanations of empirical regularities. Analysis of theory in the scientific context suggests that metaphysical and often religious propositions belong to this category, since they too are devised as explanations for phenomena that are observed.

Surely the assertions of Plato about the existence of forms and the nature of the human soul are properly characterized as theoretical rather than factual statements. Such characterization does not detract from the possible truth of these assertions, but rather suggests that the method of establishing this truth is different from that used in the case of factual or empirical statements. Similarly, assertions in Christian theology about the mode and time of ensoulment during the human gestational process appear to partake of the character of theory rather than of fact. The facts of biology may lend themselves better to

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32 *American Ecclesiastical Review*, 168 (1974) pp. 312-317.

one theory than another, but they do not prove any theory. The most that can be said is that some theories appear to be incompatible with the biological facts.

Catholic moralists of the past did not attempt to define a fact, believing that the concept was easily understood. So, in order to infer their intentions, it is necessary to examine the examples which they used as illustrations. Consider these four examples: a hunter is not certain whether the movement in the bushes is that of an animal or a human being; a druggist has reason to think that one of a number of similar bottles on the shelf actually contains poison; a woman uses a douche after rape as late as ten hours after the assault; extraordinary means of life support are terminated in the case of a terminally-ill patient when there is no probability of a return to rational consciousness. The issues involved are all factual in the precise contemporary sense: for in principle one can determine by empirical methods whether the thing in the bushes is a human being or an animal, whether a bottle contains poison or not, whether there is a fertilized ovum present in the Fallopian tube (by simply waiting), whether a person will recover from coma or illness. Other frequently-cited examples also involve states of affairs that are empirically verifiable: whether a liquid to be used for baptism is true water, whether a liquid to be used for saying Mass is truly grape wine, whether an accused person is guilty of the alleged crime (a fact that must be proven beyond reasonable doubt before conviction is justified). In no source can even one example be found which involves doubt on a point of metaphysical theory.

The only evidence available to us for judging the meaning of "fact" intended by Catholic moralists is their examples. Since these examples all appear to involve empirically verifiable state of affairs, it is thus consistent with the tradition to claim that the doubt about the time of ensoulment of the human embryo is not a doubt of fact.

Can a doubt of theory be a doubt of law? The doubt about the time of ensoulment of the embryo is of a theoretical nature; so it does not seem to fit either category of doubt proposed by moral theologians. It is not a fact in the sense in which these moralists use that term, and yet it is not directly a doubt about a law. It will, however, be argued that doubt of theory is related

to doubt of law in such a way that it is most appropriately handled within that category in the tradition of systems for resolving doubts. Three arguments can be adduced to this effect.

A doubt of law is really a doubt as to whether a formulated law actually is part of the body of natural and/or divine law. Thus there might be doubt about statements like "God has commanded that thou shalt not kill", or "God has commanded that thou shalt not kill human beings except in self- defence", or "God has commanded that thou shalt not kill early human embryos". But these statements, which do have truth value, are theoretical statements. They express a state of affairs which is not empirically verifiable. As such, they have the same epistemological status as "From conception the human embryo has a rational soul". So any doubt of law is actually doubt about the truth of a theoretical proposition concerning what God commands or the moral law demands, and such theoretical propositions have never been considered to be factual in nature.

While every doubt of law may be a theoretical doubt, it is, of course, not true that every theoretical doubt is a doubt of law. For example, doubts about assertions describing the nature and life of angelic beings do not seem to translate even remotely into doubts of law. However, in the case we are considering, the theoretical doubt about the time of ensoulment is discussed precisely because of the significance it has for the application of the law "Thou shalt not kill" and other laws protecting basic human rights. The question of ensoulment is morally relevant only because it is part of an attempt to specify the scope of the law "Thou shalt not kill". In this context, the theoretical question about the ensoulment of the embryo is equivalent to the moral question about the scope of the law forbidding killing. The doubt is therefore a doubt of law, an uncertainty about the scope of the natural and divine law against killing.

It may be objected that the law against killing has already been interpreted by the magisterium in a way that is certain. A simple formulation of the interpreted law is: "Thou shalt not kill directly an innocent human being". There is no doubt about this law. Rather, the doubt we are considering occurs because of uncertainty as to whether a particular living being belongs in the

category of human being, and this uncertainty is not a doubt about the law.

L. Rodrigo, a traditional moralist who is an authority on probabilistic methods, maintains: "Rights of an uncertain subject – uncertain by the uncertainty of the subject's existence – are automatically uncertain rights"[33]. A comparable case in law might be that of a person who vanished some years ago. Because of uncertainty that this subject still exists, the law declares that his rights are now uncertain, and, for all practical purposes, they no longer exist. Rodrigo argues that such uncertain rights may be "violated" for a sufficient reason.

The situation of a zygote or early embryo is one where the existence of a human subject is clearly in doubt. This doubt cannot be resolved even in principle, and there is solid positive evidence that a subject does not exist. So the rights of the early embryo are uncertain. The theoretical doubt about the existence of a subject translates into uncertainty about rights, and hence into a doubt of law.

Karl Rahner has involved this principle in his writings on genetic and reproductive research, arguing: "The reasons in favour of experimenting might carry more weight, considered rationally, than the uncertain rights of a human being whose very existence is in doubt"[34]. Richard McCormick applies a similar reasoning. He holds that early human embryos are "nascent" human beings but most likely not actual human beings, and hence the rights of these beings are uncertain enough to justify not granting them full moral and legal protection. He thus approves certain types of research involving fertilization *in vitro* of human zygotes[35].

We thus come to see that the theoretical doubt about the time of ensoulment of the human embryo is, in this context, equivalent to a doubt of law. The doubt is not one which endangers rights which are certain.

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33 Cf. Richard McCormick, *The Removal of a Fetus Probably Dead to Save the Life of the Mother*, Rome, 1957, pp. 395–397.

34 Karl Rahner, *Theological Investigations* 9, New York, 1972, p. 236.

35 Richard McCormick, "Notes on Moral Theology: 1978", *Theological Studies*, 40 (1979) pp. 108–109.

We may go a step further and state that even if it is a matter of doubt of fact, the problem is not insoluble. Are we always obliged to follow the safer course when we confront a doubt of fact regarding the question of life? Are we never permitted to follow a less safe course in such an ethical situation. Moralists have occasionally allowed the choice of the less safe alternative. Of course, they have permitted this alternative only where there are other proportionate values at stake, and where apparently the obligation to adopt the safer course ceased to be present. Two cases readily come to mind. First, traditional moralists such as Charles McFadden and others permit a woman to use a douche after rape as late as ten hours after the assault. Conception has been known to take place within that length of time and the woman is given the benefit of the doubt[36]. The precise existential moment of conception cannot be known for certain. Nevertheless, in the assault situation, in the absence of certitude and in the presence of the *doubt of fact*, moralists allow the woman to act without adopting the safer course – to act within the period of ten hours. To follow the safer course would have meant that impregnation and conception took place at the earliest possible existential moment after the attack or even during the attack. The second case is that of a patient who is terminally ill and unconscious. If there is no probability of his returning to rational consciousness, most moralists would permit the family and the doctor to omit the *extraordinary* means to keep him/her alive. The doubt of fact, doubt whether rational consciousness will be restored, does not entail the obligation to follow the safer of the two alternatives which would have required the continuation of all possible means.

Thus it seems that there are and there have been situations in which, in the presence of a *doubt of fact* regarding life, the safer course is not always obligatory, if other important human values are at stake. Since there is philosophical, theological, and scientific responsibility for the theory of delayed animation, this theory admittedly, not the safer of the two alternatives, might in certain situations be applied.

36 Charles McFadden, *Medical Ethics*, Philadelphia, 1956, p. 150.

Perhaps, not even a doubt of law may be resolved by probabilistic methods if human life or some other basic human right is at stake. Reference to several striking controversial issues should be sufficient to reply to this proposal. Historically, probabilistic methods have not only been used by theologians but have been recognized by the official magisterium as a legitimate way of handling doubts of law in cases where the right to life is involved. There are examples which show that the official Church has consistently relied on probable opinions in order to determine the scope and application of the natural and divine law against killing. In making judgments about the morality of capital punishment and the extent to which one may kill or disable in self-defense, the Church invokes theological opinions which have only a certain probability. In difficult life-and-death situations which arise in medical ethics, such as the termination of extraordinary means of treatment and the specification of those means, again probable opinions are cited; and in that most difficult case of warfare, the formulation of the conditions which justify entering into and waging a war can only be based on probable opinions.

Thus the official Church indicates that where there is a doubt of law involving human life or human rights, probable opinions will often offer only possible guidelines.

Before we conclude, another biological factor is worthy of note here. Traditional moral theology speaks on the assumption that a live ovum is there awaiting the sperm. Who can tell with certainty that an ovum is there, and is alive? In deciding what can be done in the case of rape, for instance, the moralist must answer these questions: Was there a live ovum present at the time of rape? If there was not, will ovulation take place during the life of the sperm? If ovulation has taken place, was the ovum alive at the time of the aggression or during it, so that fertilization may be possible? The most important factor is the presence or absence of a live ovum at the time, or near the time of the aggression. Ovulation will take place once a month; the month comprises 720 hours; the ovum will live perhaps 18 hours, or at the most 24. All things thus considered, the odds are 40 to 1 against a live ovum being present at the time of the rape. Hence we are not dealing with a probably existing embryo but rather

with an embryo whose existence is remotely possible. Remote possibility and probability are not quite the same. The odds are heavily against the presence of any embryo since there is little likelihood of a live ovum in the victim at the time of aggression.

## Conclusion

While the system of probabilism appears to be acceptable in Catholic theology, a more cautious approach would suggest using equiprobabilism. Recall that an opinion is termed probable if there are "good and solid reasons" for holding it. According to equiprobabilism, one may act with good conscience if the opinion favouring liberty is at least as probable as the restrictive opinion — in other words, if the reasons are at least as solid.

We have shown that there are good and solid reasons which appear to be at least as strong as those supporting the contrary position, for not including early human embryos under the full weight of the law against killing. Is it therefore, temerarious to suggest that termination of an embryonic life in the rare cases of rape, incest or, predictably, a seriously defective infant, during the first two weeks of pregnancy should not be regarded as foreclosed by moralists?

St. Francis Theo. College
Kottayam – 686 016

Felix Podimattam

# The Making of an Ethical Doctor

## Ethics at the heart of medical decisions

Though it may sound a bit exaggerated, it is always a truism to say that ethics belongs to the core of every medical practice. What is *right and good* for a particular patient is a question that is at the heart of every medical decision. Whenever the question of *right and good* arises, we are squarely in the realm of ethics. Therefore medical profession may be considered a moral enterprise. True, a lot of *science* is involved in the practice of medicine, in diagnosing a patient's illness and in determining the course of treatment which is relevant, useful and safe in a given context. Great *art* also is required in implementing the scientific decisions made for the well being of a patient. However, as Edmund D. Pellegrino of the Kennedy Institute of Biomedical Ethics, Washington, argues so cogently[1], the act which is specific to medicine, that which makes it medicine, and thereby distinguishes it from both science and art, is this decision about what is *right and good* for a patient who is present before the medical professional with this particular set of needs, arising out of this particular illness. This is the central and irreducible concern of every medical practice. Moreover, the question in medical decision making is about what is right and good for the patient *who is a human being*. What is right and good for an animal may not be right and good for a human being. Once the main concern of a profession is about what is *human*, we are again in the realm of values. Every medical decision, should be considered as an ethical decision.

## Ethics, the corner stone of medical training

The ethical dimension of medical practices has always been recognized at least implicitly by medical sciences. Therefore

1 E. D. Pellegrino, "The Anatomy of Clinical Judgments", *Philosophy and*

basic ethical values and attitudes were imparted along with medical training in all schools of medicine right from the beginning. In the Western world, the Hippocratic Oath functioned as a source of reference for inculcating medical trainees with the basic ethical attitudes in medical practice. Such ethical Oaths formed part of the training and initiation of young physicians in India (*Charaka Samhita*) and China (as contained in the legends of the training of Hua Tu, the great Chinese surgeon of the second century BC).

## "Osmosis" method

All this training for ethical medical practice took place through a method which can be described as *osmosis method*: the young physicians absorbed the basic ethical values and practices through their contact with their instructors and senior members of the profession. May be, it is still one of the best ways of imparting basic ethical attitudes to the students of medicine. Moral education will succeed only where the teachers and practitioners can translate in their own lives and practice the values they want to teach. As a theoretical subject, medical ethics is a systematic reflection on the values that are at work in health care profession and formulation of norms to protect these values. If the values are not adopted in real life situations and if the norms are not observed in view of protecting these values, then theorizing is a futile or counterproductive endeavour. To this day, this is the only way medical students can learn ethical principles that should govern their future profession in most of the medical schools in India.

## Need for more systematic education

Effective and laudable though, "osmosis method" is not enough in enabling a medical professional to make ethically valid medical decisions in today's world. The need for medicine to be anchored on the rock of sound ethics is all the more urgent in modern medicine. Every day newspapers are bringing us yet another biomedical breakthrough and consequent opportunities and challenges. For example, a newspaper reported the following innovations in medicine on a single day: surgery on the fetus

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*Medicine*, Vol. VI, D. Reide, Dordrecht, the Netherlands, E. D. Pellegrino, "The Fact of Illness and the Act of Profession: Some Notes on the Source of Professional Obligation".

*in utero* to correct bladder pathology; laparoscopic introduction of relief valves into the fetal cranium to prevent hydrocephalus and the subsequent retardation associated with neural tube defects, the transitional use of the totally artificial heart; *in vitro* fertilization procedures to overcome tubal occlusion. The same issue of the newspaper also heralded the good news that we are on the threshold of witnessing the production of hybridomas (man-made hybrid cells that can be introduced into the body to produce swarms of disease-fighting antibodies) and the production of interferon from DNA technology as well as the development of nuclear magnetic resonance body-imaging instead of the use of x-rays[2]. This may not be a daily occurrence, but all these advances give to human beings formidable control over life and death, genetic potential and behavioural repertoire of other human beings. They give medicine an unprecedented power to heal human beings of physical and mental diseases, to preserve their health and promote better standard of health for future generations. The new inventions and powers that scientists develop offer not only new possibilities, but also carry the potential for self-destruction and dehumanization. This power which is at the disposal of medicine can be used to make or mar human nature and destiny, if the *human* and *ethical* issues involved in modern medicine are not reflected upon with a new seriousness. The atrocities committed by learned physicians on innocent human beings during the time of Nazi reign in Germany, which were brought to light at the Nuremberg trials, are an indication of how medicine without ethics can be dehumanizing.

## Medicine without Ethics: dehumanizing

There is a letter quoted in a book by Leo Buscaglia which describes what happens when medicine is bereft of ethics. It was a letter which a survivor of a concentration camp wrote to a university professor:

> I am a survivor of a concentration camp. My eyes saw what no person should witness. Gas chambers built by learned

2 *Washington Post*, July 27, 1981, CF. Richard A. McCormick, "Bioethics and Method: Where Do We Start?", in Stephen E. Lammers and Allen Verhey, *On Moral Medicine*, William B. Eerdmans Publishing Company, Grand Rapids, Michigan, 1987, p. 55.

> engineers. Children poisoned by educated physicians. Infants killed by trained nurses. Women and babies shot and killed by high-school and college graduates. So I'm suspicious of education. My request is, help your students to be human. Your efforts must never produce learned monsters, skilled psychopaths or educated Eichmanns. Reading and writing and spelling and history and arithmetic are important only if they serve to make our students human[3].

Medical ethics is all about making medical profession more and more human. It is what is "human" that justifies the very existence of the medical profession. If the basic value of being "human" is forgotten, human medicine becomes equivalent to veterinary medicine. Every medical intervention in the life of a human being must, therefore, be considered as applied ethics. Medicine without sound ethical basis tends to spawn monumental atrocities, as cited in the letter quoted above.

Medicine without clear and conscientious ethical guidelines may be dehumanizing not only to the patients, but also to the medical professionals and scientists themselves. There is an ancient story from Sanskrit literature which might help us illustrate this painful situation of modern medicine:

> Four royal sons were questioning what speciality they should master. They said to one another, "Let us search the earth and learn a special science". So they decided, and after they had agreed on a place where they would meet again, the four brothers started off, each in a different direction. Time went by, and the brothers met again at the appointed meeting place, and they asked one another what they had learned. "I have mastered a science", said the first, "which makes it possible for me, if I have nothing but a piece of bone of some creature, to create straightaway the flesh that goes with it". "I", said the second, "know how to grow that creature's skin and hair if there is flesh on its bones". The third said, "I am able to create its limbs if I have the flesh, the skin, and the hair". "And I", concluded the fourth,

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3 Quoted in Leo Buscaglia, *Love*, Vol. V, Nightingale-Conant Corporation, Chicago, 1982. P. 30.

"know how to give life to that creature if its form is complete with limbs".

Thereupon the four brothers went into the jungle to find a piece of bone so that they could demonstrate their specialities. As fate would have it, the bone they found was a lion's, but they did not know that and picked up the bone. One added flesh to the bone, the second grew hide and hair, the third completed it with matching limbs, and the fourth gave the lion life. Shaking its heavy mane, the ferocious beast arose with its menacing mouth, sharp teeth and merciless claws and jumped on his creators. He killed them all and vanished contentedly into the jungle[4].

Clear vision and grasp of the values that are at stake in health care profession should ensure that the 'inventors' of all these revolutionary developments in medical science will not be 'devoured' by what they invent! Striking examples of developments in medical science threatening the very existence of the value for which they were invented, namely "the human", are plenty in the medical world today: the unscrupulous experiments on human embryos, iniquitous promotion of abortion and infanticide, frivolous attempts at genetic engineering, controlling or promoting fertility at the cost of all 'human' considerations, abuse of human persons as guinea pigs with no freedom and dignity, "pulling the plug" where it should not be, lucratively motivated use of life supportive systems on vegetating human bodies, are but some of them.

It is true that the new challenges and questions in medicine are the off-shoots of the technological explosion in bio-medical sciences in modern times, the questions themselves are not scientific or technological, they are necessarily ethical. The responses to these challenges and questions are always given in reference to what is good and right for a human being or beings in a given context. Casual, gut feeling-level approaches to the values contained in these situations will not, therefore, be sufficient for guiding a medical professional in taking decisions which are right and good for the patients in today's world. That's why serious

4 From *Tales of Ancient India*, translated from the Sanskrit by J. A. B. van Buitenen, New York: Bantam Books, 1961, pp. 50–51.

thought is given today in developing ways and means of inculcating a strong and healthy ethical basis in the minds of medical students in medical schools all over the world.

## The first attempts at systematic thinking in medical ethics

Attempts at systematization of medical ethics often evolved in relation to the theological traditions of various religious denominations. In the Roman Catholic Church, serious thinking on ethical aspects of medical practice developed as part of its Moral Theology. This ethics was developed and taught often outside the special professional and clinical contexts, in seminaries and other educational institutions of the Church. From the seventeenth century onwards such discussions and treatises started appearing in the Catholic Church[5]. Among the Protestant Christians, such attempts at systematization started only much later[6]. But in recent times the Protestant theological thought has been showing a lot more interest in medical ethics. Most of the recent literature on the subject shows an ecumenical approach to ethical issues in medicine. Jewish theological thinking has also given serious thought on medical ethics in recent times[7]. All these attempts at formulating principles for the ethical conduct of medical practice were from theological perspectives, and they appealed only to the conscientious followers of the respective religions. The ethics developed outside the context of the medical practice, often with little or no contact with the actual situations, was not very convincing to the medical professionals, either.

Till recently, there were only scanty attempts to formulate principles of medical ethics that were formulated by medical

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5 For instance, Carl Capellmann, *Pastoral Medicin* (1877), Giuseppi Antonelli, *Medicina pastoralis* (1891), M. P. Burke, *Some Medical Ethical Problems* (1921), Gerald Kelly, *Medico-Moral Problems* (1949), Charles J. McFadden *Medical Ethics for Nurses* (1949), Thomas J. O'Donnell, *Morals in Medicine*, (1956), and in India, George V. Lobo, *Current Problems in Medical Ethics* (1980).

6 Two volumes on medical ethics that can be mentioned here are: Willard Sperry, *The Ethical Basis of Medical Care* (1950), and Joseph Fletcher, *Morals and Medicine*.

7 Cfr. Jackobovit, *Jewish Medical Ethics* (1959), Rosner, *Modern Medicine and Jewish Law* (1972). Both these books are written according to talmudic tradition.

professionals from within the practice itself, though[8]. Systematic attempts at developing medical ethics within the context of medical practice, are of very recent origin.

## St. John's medical college: a pioneer in systematic teaching of medical ethics in India

In India, systematic teaching of medical ethics as part of the training of young doctors, does not exist in most of the medical schools. The only exception seems to be St. John's Medical College, Bangalore, where teaching of medical ethics as a systematic subject was part of the training of medical students right from the beginning of the College. This training is given at the pre-clinical and clinical years of the training, and is then extended to the year of internship. Recently, four Christian Medical Colleges of India, conducted two workshops in Bangalore to develop methods and means of introducing medical ethics as a systematic subject in these medical schools[9]. This workshop was organized by St. John's Medical college. A syllabus for teaching medical ethics and different methods of teaching it as a systematic subject during the medical education were the topics for deliberations at this workshop.

## A method of decision-making in medical ethics

The most important prerequisite for the teaching of medical ethics in medical schools, however, is developing an acceptable method of decision making, that is, a method by which we can decide what is right and good in medical profession. Often ethical decisions for medical profession are made by people from

8 Some literature on such an effort to formulate a sort of 'secular' medical ethics exists: e. g. Arnold of Villanova (a leading physician of his times 1235? – 1315?) *On the Precautions That the Physician Must Observe*; Friedrich Hoffman, *Medicus Politicus* (Rules of Prudence whereby the young physician should direct his studies and his life if he wishes to acquire and maintain both reputation and successful practice), Halle, 1738; John Gregory, *Lectures on the Duties and Qualifications of a Physician* (published sometime during the latter part of the eighteenth century); Percival's *Medical Ethics* (1803).

9 The four medical schools were, C. M. C. Vellore, C. M. C. Ludhiana, Miraj Medical Centre and St. John's Medical College, Bangalore.

outside medical practice. Seldom do these outsiders lend an ear to the insights that medical people from their concrete experiences have gained or seem to understand the challenges and tensions they have or are facing in the service of their fellow human beings. Any theory, including ethics which is not in intimate dialogue with praxis, is bound to be onesided. In critical theory[10], theoretical insights are informed by praxis and praxis is influenced by theory. What is needed is a medical ethics which is very much in dialogue with medical practice. In other words medical ethics should be both ethics and *medical*. Perhaps this is one of the basic requirements for developing a medical ethics especially where there are different religious traditions and ethical convictions existing side by side, as in the case of the Indian society. What is needed is a method which is acceptable to a wide spectrum of medical professionals, as well as one that can accommodate the religious and cultural convictions and feelings of different sections of the population. There are methods in ethics which enable us to decide what is right or wrong, and which cut across cultural and religious differences. Which of these methods is the best for developing a medical ethics in the context of Indian society today?

## Different methods

There are classical methods of decision-making in ethics. A brief evaluation of some of them should enable us to choose the one suited for a genuine *medical* ethics.

### a) Emotivism

Here what is right or wrong is decided with reference to emotional preferences. For example, regarding the question of abortion: you watch Dr. Nathonason's movie *The Silent Scream* and get horrified by the sight of a twelve week old fetus reacting

10 The term "critical theory" is used here in the Marxian sense. In Marx's thinking "critical theory" is dialectically united to praxis. It is a new awareness that grows out of the fruits of praxis. In the dialectical unity of the critical theory and praxis, the praxis is informed by the theory, and the theory is shaped by the praxis. For more about it, see Avery Dulles, "The Meaning of Faith Considered in Relationship to Justice", in John C. Haughey, (Ed.) *The Faith that does Justice*, Paulist Press, New York 19977, p. 35

pathetically and helplessly to its own imminent destruction, and screaming a silent scream before its death. On the basis of the emotional reaction it creates in you, the decision is made whether abortion is ethically right or wrong. The problem, however, is that emotions are very selectively created in people. Emotions are often the by-product of the cultural milieu in which we live. The same scene which creates compassion for the victim in some, can create excitement and sadistic pleasure in others. Many people who feel sorry for the fetus in *The Silent Scream*, for instance, may not feel sorry when they see an innocent black man getting thrashed by four white policemen some where in Los Angeles. Feelings, in other words, cannot be a criterion for deciding what is morally acceptable. Of course, emotions can become a criterion for ethics provided that we distinguish between sincere and humane and decent ones and their opposites. But how would we decide, which emotions are decent and humane? Here we need another criterion! Very often ethical debates take place on emotional grounds alone, without the debaters ever verifying the decency or humaneness of the emotions on which they found their ethical arguments. This is how ethical issues often become politicized, as in the case of pro-abortion and anti-abortion lobbies in many countries.

b) Duty ethics

Medical ethics should be based on medical facts. How does one go from facts to ethical statements which involve an "ought"? To state that things are this way, therefore they ought to be so, is to commit the "naturalistic fallacy": to argue "ought" from "is" is always bad logic and not valid in ethics. We cannot say, for example, that since in the Indian cultural context a female child is a liability and since female feticide is so wide-spread in India, it ought to be so ethically. For 'ought" statements there should be a source other than mere facts. The source of the "ethical ought" is often established in relation to the will of God, to recognized laws or customs, or to personal principles of behaviour. Customs or personal principles cannot in themselves establish what is right and good without reference to some rational principles. For many of the cultural ideals in themselves are blatantly unethical, like the caste-system and the customs that evolve out of it in our country. Appealing to the will of God,

also involves problems. How do we know what the will of God is? Often we rely on Scriptures, which reveal God's will. Often medical ethics is developed exclusively on the basis of revealed words. There are two problems in developing a medical ethics by appealing to Scriptures alone. The first problem is, in a religiously pluralistic society, which of the Scriptures is going to form the basis of medical ethics? What is binding on the Christian according to his/her Scripture cannot be binding on the Hindu or Muslim. True, followers of respective religions have every right to form their ethical convictions based on their religious preferences. They have no right, however, to impose them on others. The other problem related to developing a medical ethics based on the Scriptures is that many of the problems and challenges faced by modern medicine were not imaginable at the time these Scriptures were codified. They do not give any direct answer to many a problem in modern medicine. Sound hermeneutical approach obliges us not to look for answers to modern problems in the texts written at an age when these problems were not present even in the wildest imagination of the writers of those texts. Moreover if ethical principles are developed in medicine only on the basis of respective Scriptures, no meaningful communication and dialogue is going to be possible between professionals belonging to different religious traditions. All one can speak of here is religious ethics, not medical ethics. For example, what is right and good medically for this human being, need not be acceptable to a person on religious grounds. If a person believes that God's will is that no human being should receive blood transfusion from another human being, even if transfusion is medically indicated as right and good in the given situation, it would remain unacceptable to him on religious grounds. There is nothing wrong in a person following his religious convictions. However, in this case we are in the realm of religious ethics. How do we decide in medicine, however, whether transfusion is right and good? The logic that enables us to take this decision is what we call *medical ethics*. In the context of the pluralistic societies where we live and function today, Scriptures cannot be the only source of developing a valid medical ethics.

c) Consequentialism, utilitarianism, or situationism

Another way of deciding what is right or wrong is to find

out what brings the maximum satisfaction and causes the minimum hurt to all in the concrete situation. *Maximum satisfaction and minimum hurt* are concepts that are to be defined in relation to certain rational criteria. What are the criteria? Joseph Fletcher, a proponent of situationalistic ethics, for instance, maintains that the absolute moral rule is *love*[11]. According to him the only ethical principle is that *we must always do what is loving*. How would we, one may ask, settle abortion cases according to this principle? Fletcher would say that we must look for the consequences of having or not having abortion for this particular woman, in this particular situation, and see what would be the *loving action* in this situation. What about the obligation, then, to render loving action to the fetus, which is also considered a human being? Here we would need other ethical principles to decide what is maximum satisfaction and minimum hurt. Of course, the type of thinking proposed by this approach is very practical and realistic and must certainly form an important element in every public discussion in a pluralistic society. However, we need other criteria or basis for establishing a medical ethics which is widely acceptable. Otherwise it may very well result in proposals which may not be acceptable to many members of the community who would consider them as unprincipled, merely expedient, shortsighted, and immoral.

d) Personalism

In a personalistic method of deciding what is right and good, the criterion is the consequences of any action for the good of the persons and the community involved, but it evaluates these consequences in terms of needs and purposes which have been established not by subjective preference, nor by merely abstract laws, but *by the constitution of the human person in its individual and communal dynamism*[12]. This is the approach which seems to be best suited for developing a medical ethics in a religiously and culturally pluralistic society. Here values are intimately related to the principles of human self-realization to which all human beings, irrespective of caste and creed, are committed. The question we ask here is not merely whether

11 Joseph Fletcher, *Situation Ethics*, West Minister Press, Philadelphia (1966).

12 Cfr. Benedict M. Ashley & Kevin D. O'Rourke, *Health Care Ethics*, St. Louis, Missouri, The Catholic Hospital Association, 1978, pp. 171-178.

something is emotionally acceptable to people concerned, whether it corresponds to the customs, expectations of the society, or to the written codes in the scriptures, or whether it is bringing maximum satisfaction or minimum hurt to a person or persons in an isolated way. The decisive question here is what it is that is conducive for the self-realization of the persons involved in this medical situation. Self-realization must be understood here dynamically in relation to other persons, directly or indirectly and in relation to the *authentic human potential* of the persons involved. For instance, in deciding whether artificial insemination by using the sperm of a donor, and not of the husband, is ethical or not, the question a personalistic approach would ask is: how is this procedure going to affect the self-realization (happiness in a wider context) of the persons involved here: the woman, the husband, the child which is going to be born through this process etc. It is on the basis of the findings of this discussion the ethics of artificial insemination from a donor is decided. Here the question is not whether artificial insemination corresponds to the written regulations of the Scriptures, or the accepted custom and practice of a given culture, but, whether it corresponds to the basic exigencies of the self-realization of the persons involved in this situation. These exigencies can be considered as the "law of God" written in the dynamic nature of human beings.

The personalistic approach is based on the holistic view of the human person. The definition of health proposed by World Health Organization (1959) is supporting this holistic view of human person and his/her health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Although this definition is accepted not uncritically by everyone[13], it points to the fact that *health, well-being* or *self-realization* cannot be reduced to the parameters of biological or individualistic well-being. Consultations are taking place all over the world to include *spiritual* dimension also in the definition given by W.H.O. acknowledging the fact that the spiritual also should form part of the criteria of well-being or health. If well-being or health is going to be decided on the basis of this holistic approach to a person's self-realization, then

13 Daniel Callahan, *The Tyranny of Survival and Other Pathologies of Civilized Life*, Macmillan, New York, 1973.

we may be able to conclude that *what is medically right and good, is also ethically good.* Here we are not referring to the opinion of one or two medical practitioners or even teams of physicians. What is required here is a sincere and ongoing search to discover what is medically good for the self-realization of a human being in his/her dynamic nature with its personal, social and spiritual dynamisms. This approach seems to be conducive to fostering a commitment on the part of the medical professionals, for an on-going search for what is really right and good for the patient according to the information and insights available in the medical science of a given time. "What is medically right and good" is not always easy to decide, though. I remember a discussion that took place in an emergency situation in a hospital where a team of gynecologists decided that termination of pregnancy was the only way to save the life of a woman with serious cardiac problems. According to them what was right and good for this woman in the given context was medical termination of pregnancy. Two other doctors disagreed, arguing that if this woman could stand the strains of undergoing termination of pregnancy, she can very well stand the strain of bringing the pregnancy to term. In other words, to the question "what is right and good" for the patient medically, there may not be a unanimous answer. Still, the criterion for deciding what is ethically acceptable in this situation will be the search for finding out what in reality is medically good for the patient. This is likely to promote an honest and ongoing search for the real medical and ethical values from the part of the physicians and scientists.

The Personalistic approach seems to be the best method suited for developing medical ethics in the medical schools in India. The advantage is that people with different religious convictions, even those with none, can take part in this ethical search for finding out what is right and good for a human patient. No doubt that this search can be facilitated by the religious traditions and convictions that individuals possess.

It must be admitted that there may occur disagreements between the judgment of the medical science and the verdict of the religion regarding what is right and good for a patient in a given context. Recently there was a case of Yahowa's witness,

who was admitted to a well known hospital in our country with a diabetic foot and with severe anemia. The doctors attending to him decided that what was right and good for him was to give him blood transfusion without which the diabetic foot would not heal. This option, however, was unacceptable to the patient on religious grounds. He preferred the next option that medical science could offer: amputation of the leg, which was, if not the best medical option in the given situation, still a viable solution medically. The doctors obliged him and proceeded with amputation. What is medically good and therefore ethically good, need not be acceptable on religious or cultural grounds to the patient. In such situations the medical professionals will be able to tolerate or even appreciate the preference of the patient and look for procedures or treatments that are not offensive to the patient's religious feelings. However, if the second option was medically not right and good, then the doctors could not oblige the patient. For instance, if the patient in the above mentioned situation asks for termination of life, the physicians who do not accept this as a right medical option, cannot oblige the patient. When there are discrepancies between medical science and religious beliefs regarding what is right and good, both medical profession and religious convictions can profit through a soul-searching, and possible reevaluation and reformulation of their respective premises. That is the nature of the critical theory, as mentioned earlier in this article. Medical science will be able to examine some of its unverified, culturally biased premises more closely; more insights may be shed on the nature of the religious beliefs and tenets, leading to a better understanding of the principles involved.

## The content of the curriculum

Before concluding this article, a few words about the curriculum of ethics in medical teaching seems to be appropriate.

Very often in the teaching of Medical Ethics, people tend to focus their attention on some marginal issues like the question of test-tube babies, euthanasia, abortion, organ-transplantations, and so on. Medical ethics, however, as its standard definition points out, deals with those ethical principles that *govern professional conduct* in medicine. A lot more attention, therefore, must be given to those principles that should govern the day to

day practice of medicine, rather than just to some peripheral issues. The code of Medical Ethics approved by the Medical Council of India rightly concentrates on these principles: the character and responsibility of the physician, solicitation of patients, payment for services rendered, duties of the physician towards their patients (patience, delicacy and secrecy etc.), duties of the physician to the profession at large (upholding the honour of the profession, safeguarding the profession, duty to expose unethical practices of the profession), dealing with other members of the profession, duties of the physician to the public etc. In developing a curriculum of medical ethics, stress can appropriately be given to these areas of day to day practice. Practical training in acquiring the necessary communication skills for dealing with patients and colleagues must be part of the curriculum.

In the teaching of medical ethics, there should be clarity regarding the distinction between values and norms. *Value* can be defined as something good that is worthy of realization in one's life. When I understand that cleanliness (*something good*) for example is worthy of realization in my life, i.e., if I realize the value of cleanliness in my life, my life is going to be more meaningful, then cleanliness becomes a value for me. *Norms*, on the other hand, are concrete ways of translating these values into my life. A daily bath, cleaning the house and premises, changing the dress etc. can be norms that enable me to translate the value of cleanliness into my life. At times, people tend to equate values and norms, and discuss norms as unrelated to values. Norms are valid only to the extent they enable us to realize the values in our lives. In the teaching of medical ethics norms must be discussed in relation to the values they are supposed to be protecting. For example, the norm "not to practice abortion" is related to the value of respect for human life. The above norm is one of the means of realizing the value of respect for life in one's life. When the value is forgotten, and norm becomes the focus of attention, the very value it is supposed to protect is often violated in practice. For example, people who dedicate their lives for fighting against abortions, at times betray callous disregard for the lives of people with whom they work or of people who hold a different view, and often violate the value of respect of human life in their crusade against abortions. Or, people who condemn

euthanasia, end up promoting it in practice, by prescribing hazardous drugs, and so on. In the teaching of medical ethics one cannot forget that the understanding of the values can and should deepen and that norms must be revised accordingly.

The central issue in medical ethics is respect for human life. Mark Twain once complained that people were always talking about the weather but they never did anything about it. The same seems to be true of the humanhood agenda in bio-medical ethics. Ethicists are constantly saying that we need to explicate humanness or humaneness, what it means to be a truly human being, but when it comes to defining what is human, people shrug off its feasibility. A lengthy reflection on what is human is essential in a curriculum of medical ethics.

Since respect for human life is exercised in Medicine in the context of health, illness and healing, proper vision of these realities which transcend the boundaries of the physical and the biological, can helpfully be included in this curriculum.

A convenient way of dealing with ethical issues in the practising of medicine seems to be the division of them into three different areas of a person's life: a) Medical ethical issues relating to the beginning of a person's life, b) relating to a person's life during its course, c) relating to a person's life towards its end.

Ethical issues that arise from recent progress in biology and medicine, since they may be intimately related to the practice of medicine, can form part of the curriculum at least at an advanced stage. This part of ethics is known as bioethics. A discussion on whether this discipline must be re-christened as *Bio*-medical ethics, instead of just medical ethics, is called for in the context of implications these advances have for health care profession and in view of the involvement of the medical professionals in such researches.

St. John's Medical College
Bangalore

Thomas P. Kalam

# Artificial Insemination and In Vitro Fertilization

As far as we know, the first test-tube baby, Louise Brown, was born in 1978 in Oldham, a town in Northwestern England. Louise was hailed as the "miracle child", "the baby of the century" and so on. Due compliments were paid also to Patrick Steptoe and Robert Edwards, renowned gynaecologist and reputed physiologist respectively, who steered this venturesome process to successful completion. At the same time, warnings were also sounded by jurists, theologians and even scientists regarding the legal, ethical and social implications of the new achievement. Today, however, test-tube (born of *in vitro fertilization*) babies do not create any news. There are several hundreds of them around the globe. Sometime ago it was reported in a periodical that a gathering of test-tube babies held on 20th May 1990 in Manchester (England) was attended by 600 of them which was nearly only half of the total estimated number of test-tube babies around the world[1]. Besides, in the meantime many reproductive centres and clinics have sprung up in different parts of the world, several of which go about their business with fanfare and publicity while Drs Steptoe and Edwards did their job very secretly or even secretively in the District Hospital of Oldham. India too has her share of test-tube babies of whom the first was born in 1986, and the facilities for test-tube reproduction are today available in several of our major cities[2].

Another reproductive technique which is also common today is artificial insemination, but this is much simpler than reproduction in a test-tube. Though both of these are becoming

1 *Vanitha*, Sept. 15–30, 1990, p. 16.

2 Dr. Indira Hinduja, "Hi-tech Pregnancies" in *Science Today*, Jan. 1992, p. 47.

ordinary phenomena, the legal, moral and social problems and implications centered on them have not been adequately clarified. There are positive, negative and mixed reactions to these procedures. In 1987 the Vatican Congregation for the Doctrine of the Faith issued an "Instruction on Respect for Human Life in its origin and on the Dignity of Procreation. Replies to certain Questions of the Day" (henceforth referred to as 'Instruction') dealing with the morality of the various recent medico-technological interventions into the procreation of human life. Artificial insemination, reproduction in test-tube, surrogate motherhood, sperm bank and foetal experimentation are the more common ones among such interventions. However, much of the dialogue among catholic moral theologians is probably centered on artificial insemination (AI) and in vitro fertilization (IVF). Therefore, this article is a summary presentation of the catholic moral teaching on AI and IVF and of the ongoing reflections about it. We shall first consider AI and then IVF.

## Artificial Insemination (AI)

AI refers to the process and technique of bringing about a human conception by transferring into the genital tract of a woman the sperm previously collected from a man. This is further distinguished into *homologous*, if the sperm has been collected from the woman's husband (AIH), and *heterologous*, if the sperm has been obtained from a donor (AID), i.e., somebody other than the woman's husband.

AI is usually resorted to when conception through natural sexual intercourse is not possible for physiological or emotional reasons. Children are the fruits of the mutual love of husband and wife and every couple naturally longs for at least one or two children. Catholic morality also has always taught that begetting and bringing up of children is an important purpose of marriage. Lack of children can adversely affect the happiness of the couple, their sense of fulfilment and even their mutual fidelity and commitment. In this context, AI is considered a great boon to such suffering couples. Science and technology are supposed to work for the good and happiness of man, and many consider AI technique to be such a good application of medical technology for the good of infertile couples.

## Morality

The morality of such procedures however cannot be properly assessed merely on the basis of the benefit and happiness they provide to childless couples. A major consideration in their moral assessment is whether such a procedure respects the inner structure and meaning of the sexual act. The sexual union of a married couple is the expression of their intimate personal love for each other, it is at the same time oriented to the procreation of a new life. Thus, two dimensions – expression of mutual love and openness to procreation of life – are integrated into the act of genital union. Due respect to the structure and meaning of human sexuality and sexual act requires that the unity of love and life dimensions be preserved; these dimensions may not be separated. Consequently, the procreation of a child should take place in and through the genital union of the couple, which is also the expression of their mutual love. This love-life unity is the sign of a deeper unity, that of the material body and the spiritual soul in man[3]. Further, this unity has its transcendent foundation in God, in whom personal communion (love) and creative fatherhood (life) are supremely united[4]. As Johnstone notes "...man and woman, in marriage, are called to loving relationships which reflect the loving, life-giving, personal nature of the divine relationships"[5].

Artificial insemination in which the generation of a new life takes place outside the sexual union of the couple therefore does not respect the above-said love-life unity, it is a procedure which replaces the conjugal act and hence morally illicit[6]. Besides AI is criticized for mechanizing human procreation and thus reducing man to an object of scientific technology[7]. Another moral consideration regarding AI is how the sperm required is procured. Methods of sperm-procurement which blocks the possibility of natural conception (e.g. self-stimulation, interrupted intercourse and the use of condoms) are also dissociative of the love-life

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3 *Instruction*, II / 4.

4 *Instruction*, Introduction, 3.

5 B. V. Johnstone, "The Instruction "Donum Vitae" and its reception" in *Studia Moralia*, 26 (1988), p. 221.

6 *Instruction*, II / 4, 6.

7 *Instruction*, II / 4.

dimensions of human sexuality and sexual act and are therefore illicit. Such methods add to the immorality of the AI procedure[8].

Both AIH and AID are illicit for the above reasons. Besides, AID contains an additional malice. It goes against the unity of marriage and the fidelity expected of the spouses. A third person, through the sperm he has donated, so to say, intrudes into the one-to-one commitment and fidelity of the spouses. Thus, the spousal and parental vocation and obligation to generate children through mutual giving is also violated. Further, in AID the child is denied the opportunity to be born into an atmosphere of filial relationship based on genetic bond and stable family. In fact, the child is in the dark about the very identity of his genetic father. As the Instruction notes, there is "rupture between genetic parenthood, gestational parenthood and responsibility for upbringing[9]. All this adversely affects the proper growth and development of the child, which in turn has unhealthy and damaging consequences for the society, for family is the basic unit of the society[10].

## In Vitro Fertilization

This refers to the process and technique used to obtain a human conception by allowing the gametes of a man and a woman to fertilize in vitro (glass dish, tube) and then transferring it into the womb of the woman. Its full name therefore is in vitro fertilization and embryo transfer (IVF-ET). This is resorted to when the meeting of ovum and sperm and consequent fertilization is not possible within the body of the woman for certain reasons, especially damage or block in the fallopian tubes. Medical technology again comes to the aid of such people providing them the opportunity to bear a child. IVF also can be by husband or by donor depending on whether the ovum of a woman is allowed to be fertilized with the sperm of her husband (IVF-H) or with that of a donor (IVF-D).

### Morality

The morality of these procedures is also to be assessed in the light of the principles we have already mentioned while discussing AI. It is then easily seen that IVF-H suffers from all those

8 *Instruction*, II / 6. 9. *Instruction*, II / 2. 10. *Ibidem*

deficiencies characteristic of AIH: dissociation of the love-life dimensions of sexuality, substitution of medical technology for personal sexual union of the couple and probably also illicit method of sperm-procurement. Besides, in IVF the generation of a new life is more seriously dissociated from the human body since it takes place in vitro. This is domination of technology over human procreation and hence contrary to human dignity[11], observes the Instruction. Further, in IVF several ova are fertilized simultaneously in order to ensure the availability of one or a few healthy ones fit for transfer to the womb. The unfit ones are destroyed. Thus several embryos come to be rejected and destroyed, at least in the present state of medical technology, for the sake of one child. If there are surplus healthy ones which are not immediately transferred to the womb, they are sometimes frozen and kept for eventual future use. But who has the right to throw away, destroy or freeze and keep human embryos in this manner? It is a violation of the dignity and the right of innocent human beings. Therefore, besides possessing all the moral flaws of AIH, IVF, whether by husband or by donor, has these serious moral difficulties associated with it. The observant reader will also easily notice that IVF by donor is morally more flawed than that by husband because the former involves the breach of the unity of marriage and the mutual fidelity of the spouses, together with the rupture of genetic and gestational parenthood and its attendant consequences for the child and the society.

Though IVF is usually beset with various moral difficulties, several of them can be eliminated provided proper care and responsibility is taken with regard to the following factors: fertilization should be with the sperm of the husband, sperm should be obtained through licit means (e.g. use of perforated condom), do everything possible to avoid the destruction of embryos during the procedure (this may be better realized with the advance of medical technology). Such IVF procedure with "reduced evil" is called the "simple case". However, even the simple case is morally objectionable[12] because of the other moral defects it contains, especially the dissociation of the love-life dimensions of sexuality and technicalization of the human procreative process.

11 *Instruction*, II / 5.
12 *Ibidem.*

Thus, we see that all the artificial methods of insemination and fertilization are morally wrong. Making a comparison among the various procedures, we may say that IVF-D is the most objectionable, followed by AID. Then comes the simple case of IVF-H and finally AIH.

## Licit interventions

The Instruction considers certain artificial interventions in procreation as licit. The characteristic of such licit interventions is that they do not replace the conjugal union but only help the conjugal act to attain its goal. "Homologous artificial insemination within marriage cannot be admitted except for those cases in which the technical means is not a substitute for the conjugal act but serves to facilitate and to help so that the act attains its natural purpose"[13].

However, the Instruction does not specifically say which all procedures are licit. All the same, there seems to be an understanding that Low Tubal Ovum Transfer (LTOT) and Tubal Ovum Transfer with Sperm (TOTS) are among the licit procedures. TOTS is more popularly known as GIFT (Gamete Intrafallopian Transfer)[14]. LTOT involves surgically taking an ovum and placing it beyond the point of any obstruction in the fallopian tubes so that there it can be fertilized after a natural intercourse. However this procedure has not been successful in obtaining conceptions[15]. TOTS involves surgically extracting an ovum, placing it in a catheter along with a sperm which may be obtained during intercourse by the use of a perforated condom. The ovum and sperm are kept separated so that IVF does not take place. Then both sperm and ovum are injected into the fallopian tube in such a way that they meet each other only in the body of the woman. Both the procedures are considered to be licit since sexual intercourse takes place in the normal way and conception, if it takes place, occurs in the body. TOTS is reported to be successful, more successful than even IVF[16]. D. G. McCarthy consultant at

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13 *Instruction*, II / 6.

14 E. V. Vacek, "Vatican Instruction on Reproductive Technology" in *Theological Studies*, 49 (1988), p. 131; D. G. McCarthy "TOTS is for Kids" in *Ethics and Medics*, Dec. 1988, p. 1.

15 McCarthy, *Ibidem*.

16 McCarthy, *Ibidem*; Hinduja "Hi-tech Pregnancies", p. 47.

the Pope John XXIII centre for Biomedical research and Ethics, Massachusetts, notes that many fertility specialists who use the TOTS (which they call GIFT) procedure to help infertile women do not do it in association with the natural sexual union of the couple. Then it becomes a substitute for conjugal act, not assistance. Such a practice of TOTS or GIFT is therefore illicit[17]. However, for GIFT (or TOTS) to succeed, the woman should have at least one Fallopian tube that is morphologically and functionally normal[18]. The involvement of medical personnel in these procedures is taken to be assistance, not replacement of natural conjugal act. Still, since there is considerable intervention between the sexual intercourse and conception, there has been a suggestion to proscribe these methods[19].

## Ongoing Reflections

At a time when different types of interventions into human procreation began to show signs of proliferation the Instruction from the Vatican appeared as a good guide not only for those who acknowledge the moral teaching authority of the Church but also for those who are open to the vision of the Instruction. In the light of the Church's traditional and previous teachings, based on faith-vision and natural reflection, the Instruction gives principles for the assessment of today's major technical interventions into human procreation. However, the biomedical field which is the context of application of these principles is a very complex one and is fast progressing too. The clarity of general principles and the cogency of arguments may be obscured by diverse relevant considerations. Therefore, biomedical ethics has to dynamically keep pace with the expanding domain of medical science and technology. The Instruction also affirms that the directions it offers are not meant to halt but stimulate further reflection paying, of course, due respect to the teaching of the Church[20].

While the Instruction's uncompromising stand for the defense and promotion of the dignity of the human person, human life

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17 McCarthy, *Ibidem.*

18. Hinduja, *Ibidem.*

19 Vacek, "Vatican Instruction", p. 131,

20 *Instruction,* (Conclusion)

and sexuality is appreciated, many, including catholic moralists, think that its stand has been too rigid on certain issues, especially homologous artificial fertilization including IVF-H and AIH. Concerning this they raise several questions which need further consideration and clarification. The following are important ones among such questions.

## 1. The inseparability of love-life dimensions

The unity of love-life dimensions is to be respected and promoted, but is it so inseparable as the Instruction demands, ask several moralists and ethicists. Regarding the inseparability principle which is the main argument against IVF-H, Vacek says: "Here there is disagreement not only over some applications but over the inseparability principle itself – and not by a few but by many, including catholics. Most of the christian ethicists and ethical committees surveyed...either have no moral problems whatsoever with homologus artificial reproduction or approve it with qualifications"[21]. All agree that generation of life and marital love are linked; that a new life may be generated only as the fruit of parental love. But they do not think that sexual union of the couple is the only vehicle of this love so much so that the generation of a child outside of sexual union would be tantamount to a life conceived without love. As R. McCormick, the eminent American moral theologian, says "sexual intercourse is not the only loving act in marriage"[22].

In fact there are several genuine expressions of marital love[23]. Mutual care and concern of the couple and their cooperation in various family affairs is one. Bodily intimacy and sexual union is another important mode of expression, and this is specially significant because this tends to the generation of a new life. But still the generation of a new life through genital union will not be a loving act or expression of love if it is not permeated by the mutual care, concern and commitment of the couple. What else are the criteria of genuine personal love and communion? Genital intercourse by itself, we know, is not a sure criterion or expression of love as it is amply proved by instances of prostitution and rape. Therefore, what makes the sexual union of the

21 Vacek, "Vatican Instruction", p. 128.

22 *Ibidem*, p. 115. 23. *Idem.*

couple personal meaningful and loving is their mutual care and commitment. These are to be present not only during the sexual intercourse but also before and beyond it. Is not a generative act – eg. IVF simple case - inspired by such love, one endowed with the unity of love and life dimensions?

A couple's creative hope for a child is a significant expression of marital love[24], because a child is the fruit of parental love. Therefore, if a couple who earnestly desires a child but suffers from a defect which blocks the realization of their desire in and through natural intercourse, has recourse to medical technology, can we say that love and life have been split in such a case. Can we meaningfully deny that such a child is the fruit of parental love? Considerations like this make it difficult for many ethicists and moralists, including Bishops, to understand the Instruction's unqualified rejection of homologous reproduction as immoral[25].

It may be noted that significant Orthodox theologians concur with the Instruction and with most catholic theologians in their rejection of heterologous IVF and AI as morally unacceptable. But they accept homologus IVF and AI as licit. These are understood to be within the ambit of marital love and conjugal fidelity and applications of medical knowledge for realizing the procreative goal[26]. In other words, according to the Orthodox understanding the sexual union of the couple is not the only type of activity in which love and life may be united. Similarly, the Ethics Committee of the American Fertility Society which agrees with the Instruction that the child conceived must be the fruit of parents' love cannot understand the position that this love must, in all circumstances, mean sexual intercourse. It wonders how separating the unitive and procreative in an individual act can be the separation of the goods of marriage. The goods of marriage, the Committee observes, involve the relationship, not necessarily the individual act. According to the Committee, therefore, artificial procreative procedures are not to be considered as replacement of sexual intimacy, but as its logical and technical extension[27].

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24 *Idem.* 25. *Ibidem.* p. 128.

26 Johnstone "Donum Vitae", pp. 213, 217.

27 *Ibidem*, p. 218.

## 2. Divine reality and human analogate

The unity of love and life dimensions required in the conjugal act, as noted earlier, is founded on the unity of love and life in God. Since Johnstone makes a penetrating analysis of this, digesting also the thought of some other authors, let us hear him in some detail: "Since love-union and creative fatherhood are present and are united in the personal divine reality, they must also be present and united in the personal human analogate, that is, in the marriage relationship of love. The logic of personal donation in marriage is linked as symbol or as analogate, to the logic of divine love"[28]. But this by itself does not demand that the unity of love-life dimensions be realized exclusively in the conjugal act, for this line of argument "leads to conclusions about the inseparability of love-union and procreation in relation to marriage as a totality...but...not...in respect to particular acts within marriage"[29]. For this, there is a specific basis at the next level, namely, the soul-body union of the human person. It is spelled out as follows: "The goods of marriage (love-union and procreation) as goods of the spirit, are at the same time, embodied values, that is, values realized in and through the physical structures of the human body. The particular physical structure in which these goods are realized is the conjugal act"[30]. This argument therefore has a "multi-level structure, where levels are linked to the other levels as symbols or expressions. At the highest level is the giving love of God. This is symbolised and expressed in the giving love of the couple, which is a participation of it. This giving is symbolized and expressed in the logic of the body, which in turn is expressed concretely in the act of sexual intercourse. The normativity of each level of structure derives ultimately from the normativity of divine love itself"[31].

Two observations come to mind immediately. One, arguments from symbolism and analogy should be made cautiously. Symbols, especially in theological parlance are used to express aspects of the divine which is transcendent. Therefore, we cannot insist on strict parallel between the symbol and the symbolized. Similarly, there cannot be strict correspondence between the (divine) model and its (human) analogate. The nature of the dimensions and the

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28 *Ibidem*, p. 221. 29. *Ibid*, p. 222. 30. *Ibid*, p. 223. 31. *Idem*.

mode of their unity in God and the human are not the same, though something similar. The attributes of love and life, for example, do not create any complexity in God, but not so in humans. While God's love is always perfect, creative and life-giving, human love is limited, deficient and sometimes unproductive as in the case of a sterile couple. If we insist on strict correspondence in analogy, it can also be argued that a human analogate whose love fails to be productive (e. g. an infertile couple) should resort to any available means in order to make itself productive and thus correspond to the divine model which is always creative and life-giving. Arguments from analogy, we feel, should take a holistic approach, not draw strict parallels.

Second, normally the soul expresses itself through the body. But the dynamism and creativity of the spiritual soul need not necessarily be confined rigidly to the biological structures of the body. Think of how computers today have taken up the multifarious computing and organisational operations so far done by the human brain. Further, should the creativity of the spiritual soul be restricted even by the deficient structures and functions of the body, as in the case of an infertile couple? If so, which is of greater significance for us: the creative powers of the soul or the limiting structures of the body? It is difficult to appreciate fully an argument which in its conclusion forgets nuances of analogy and complexities of the soul-body union and draws rigid normative conclusions for human behaviour predominantly on the basis of biological structures. It sounds something like a reasoning which draws an 'imperative conclusion' from a 'subjunctive major' premise and an 'indicative minor' premise.

Johnstone also contends that this symbolic-analogous argument is not 'biologistic'' because its weight lies not in the "normal pattern of the act" but in the "rational order" behind it. However, he further notes that this rational order is not "simply that order or laws discoverable by reason in human reality, including human biological reality"... but rather "a kind of total, symbolic value organism, embracing the religiously grounded values of love and procreativity, the values of personhood and the biological structures, through which persons express love and procreativity"[32]. This sounds much more integral and personal. But

32 *Ibidem*, p. 225.

within such an integral-personal perspective we cannot draw rigid, exceptionless norms for human procreation on the basis of the meanings of the sexual act alone, ignoring other values and goods of the couple, their marriage and the family. But if such norms are so derived, such a position, we feel, is at least biologistically biased.

### 3. Science: subhuman?

The Instruction appreciates the positive contribution of science and technology while warning against its abuse. Employing medical technology, however, for obtaining human procreation is said to be domination of technology over humans as well as a procedure which undermines human dignity. It is also shown to be another reason for proving the evil of IVF.

But several considerations dissuade many from reaching such a conclusion[33]. First, medicine is evidently a human activity, not a subhuman one. Hence, the use of medical technology for human procreation is also quite a human enterprise. But it is argued that such procreation is devoid of the immediately intimate context of genital union[34]. That is true. But why should it be insisted that generation of life may happen only in the immediate context of the personal intimacy of the couple. What is important is the overall personal intimacy that prevails between husband and wife not necessarily the one that is centered around their genital union alone. A couple has a lot of opportunities to develop and foster such personal intimacy. Resorting to IVF does not impede a couple from enjoying and expressing such intimacy either.

Regarding the "humaneness" of technology Vacek brings in a useful comparison[35]. Eating usually takes place among us in the context of love and companionship. But when necessary we resort to medical technology for intravenous feeding which we do not at all consider as subhuman or below human dignity. Intravenous feeding of a sick person by the medical personnel in a hospital environment may not at all evoke the feeling of love and companionship as usually experienced in a family meal; but giving IV feeding to a person who needs it is a special gesture of care and companionship.

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33 Vacek, "Vatican Instruction", p. 116.

34 *Ibidem*, p. 117–118.

35. *Ibidem*, p. 116.

Besides, here science and technology are not dominating over the human but placed at his/her service. In fact, it is the infertile couple who, realizing their naturally helpless situation, approaches the physicians with the request for a viable and prudent use of scientific techniques for remedying their problem. Though abuses are possible, responsible and expert physicians in such a situation would do the best they can to remedy the difficulty. It would then be a prudent and reasonable exercise of human dominion over nature than the domination of the latter over the human. How frequently now-a-days are the people, young and old, "connected" to medico-technical equipments like ventilator, respirator, heart-lung machine etc., which take up the functions of some of the vital organs and keep the person alive. The person may be said to be "at the mercy of the machines". But still, we do not consider it a domination of technology, but legitimate use of technology for the good of humans. When machines "replace" vital human organs for various periods of time, we do not consider it illicit. Why should we think differently of IVF in the case of an otherwise helpless couple?

Some may insist that technology is all right for treating diseases and critical conditions, but not for the production of a new life, which should take place in the natural way. To this it may be responded that it is a natural and legitimate human feeling which should be respected in the normal course of events. But it is not easily seen nor can it be proved that this feeling is so sacred and inviolable that it cannot yield to the equally strong or even stronger 'natural and legitimate' feeling to have a child of one's own. What is more important than the respect for such a feeling would be the couple's care and concern for the child they are hoping for.

## 4. Integral personalism needed

In its introduction, the Instruction repeatedly states that science and technology should work for the integral development of humans and it is then that they become valuable to them[36]. Integral vision is again affirmed when it speaks of the realization of the human person as a unified totality, consisting of corporal and spiritual dimensions[37]. But, speaking more concretely, for

36. *Instruction.* (Introduction, 2, 3).

37. *Ibidem*, 3.

example, about homologous IVF, the Instruction says that its morality is to be judged in itself and not from the totality of conjugal life[38]. Thus, at the normative level the Instruction drifts from the integral-personalistic approach affirmed in the introduction to a partial, even biologistic approach. In the opinion of S. Callahan and L. S. Cahill, both married women and ethicists, the proper starting point for the moral assessment of the reproductive technology is not the nature of one genital act, but that whole which is the partnership of the married couple[39]. "No 'act analysis' of one procreative period of time in a marriage can do justice to the fact that the reproductive couple exists as a unity within a family extended in time and kinship"[40], notes Callahan further. These authors do not mean to ignore the significance of the structure of the sexual act, but make a plea for personalistic and integral criteria of assessment.

The good of marriage involves a network of relationships and a hierarchy of 'intermediary goods' which should be given due consideration in assessing the morality of any one factor. In married life, the mutual love of the couple, respecting the biological dynamism of the sexual act, having a child, bringing up the child properly etc., are important goods. For a childless (infertile) couple having a child of their own is a very significant good. Thomas Shannon, noted American bio-ethicist, says IVF serves what many consider an essential need: a child to complete their marriage[41]. A couple's deep-seated desire or drive to generate a new life is normally considered to be an essential part of being human: a basic good[42]. But it does not at all seem to be an important consideration for the Instruction. The Instruction is also aware of the suffering of infertile couples, but at the normative level it speaks from the framework of the natural structure and orientation of the sexual act[43] than from an integral view of the goods and values involved.

## 5. Lack of perfection vs evil

As we saw earlier in this article, the Instruction considers artificial procreative procedures as illicit because they fall short of the ideal or perfection, i. e., they do not correspond to what is normal and natural. "But from the moral point of view

38 *Instruction*, II / 5. 39. Vacek, "Vatican Instruction", p. 118.
40 *Idem*. 41. *Ibidem*, p. 119. 42. *Idem*. 43. *Instruction*, II / 8.

procreation is deprived of its proper perfection when it is not desired as the fruit of the conjugal act, that is to say, of the specific act of the spouses' union[44]. We know that nature itself does not always function normally or perfectly. In fact, people are constrained to resort to IVF precisely because their generative faculty/organs are not functioning normally and perfectly. When scientific knowledge and technology are used to remedy a deficiency in nature so as to enable it to attain its goal, can we call it illicit because it falls short of its proper perfection?

Human life in various situations is guided by certain ideals and aspirations. But life in concrete is beset with various limiting factors so that frequently we have to be satisfied with what is less than the ideal, with regard to the goal and/or the means employed. Many new-born children, for example, do not enjoy ideal or normal health; many parents can afford only inadequate care for the health and growth of their children. Because these are less than the ideal, they do not become illicit or immoral. In other words, the alternatives to the ideal are not necessarily illicit or immoral. There are intermediary levels of 'good' which can or should be realized. The meaning and message of the well-known moral "principle of lesser evil" is not something different. "Modern life seems to present more and more situations where the only choice is between the greater and the lesser evil, between the unsatisfactory and the more unsatisfactory. This is true in the church and in politics, in business, in science, in medicine, in peace and especially in war[45]. But the Instruction's approach seems to be idealistic, as Vacek notes: "The typical logic of the vatican's sexual ethics, it seems to me, is to state the ideal and then to insist that anything wilfully short of the ideal is sinful. It slides from "best way" to "only way". That is, in intention sexual activity must be structurally perfect, or else it must not be. For the Instruction, the ideal and therefore only way for the child to be conceived is as a result of a loving genital act; hence reproductive technologies are wrong"[46].

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44 *Instruction*, II / 4, 5.

45 G. W. Healy, "Choosing the lesser evil: use and abuse" *Landas*, 8 (1989), p. 119.

46 Vacek, "Vatican Instruction", p. 129.

In fact. it is not correct to say that the Instruction does not at all use the principle of lesser evil. It seems to do so in the case of adoption. The Instruction considers negatively any rupture between genetic parenthood, gestational parenthood and the responsibility for upbringing[47] and forbids such rupture. This should proscribe adoption, for in adoption there is a rupture between the responsibility for upbringing and genetic/gestational dimensions of parenthood. But still, the Instruction suggests and even encourages adoption as a good service which physically infertile couple can take up[48]. Thus it tolerates the evil of rupture in order to avoid a greater evil, i.e., the deprivation of family care and consequent dangers for orphaned children. Regarding this, the observation of Krauthammer is pertinent: in adoption there is no genetic connection whatsoever between the child and the parents, and that in no way invalidates the notion of family... It may not be the ideal family, but it is the best people can do[49]. Is not a similar consideration possible for IVF-H, especially "simple case", in the case of an infertile couple who longs for a child of their own? Some tend to think that it is the Catholic morality's preoccupation with sexuality that persuades it to set sexual activity in a special category outside normal ways of understanding human activity and exempt it from the usual ways of doing ethics[50]. Hence, the Instruction applies the lesser evil principle, which is a general principle in ethics and morality, to adoption which involves caring for the child, but not to IVF-H, which involves generation of a child which is supposed to involve sexual activity. Is sexual activity so unique, ask the critics. If so, so are other human activities like prayer, work, worship, eating, flying etc. each having its specific significance, possibilities and limits[51].

Concluding these reflections, we should like to note that our considerations focussed only on some major aspects of the issue. Interventions into human procreation may be done only with utmost respect for the person and his integral good and well-being, as the Vatican Instruction emphasizes. This integral-personal perspective needs to be reflected also at the level of moral norms.

Thomas Srampickal

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47 *Instruction*, II / 2. 48. *Instruction*, II / 8.
49 Vacek, "Vatican Instruction", p. 127. 50. *Ibid*, p. 129. 51. *Idem*.

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